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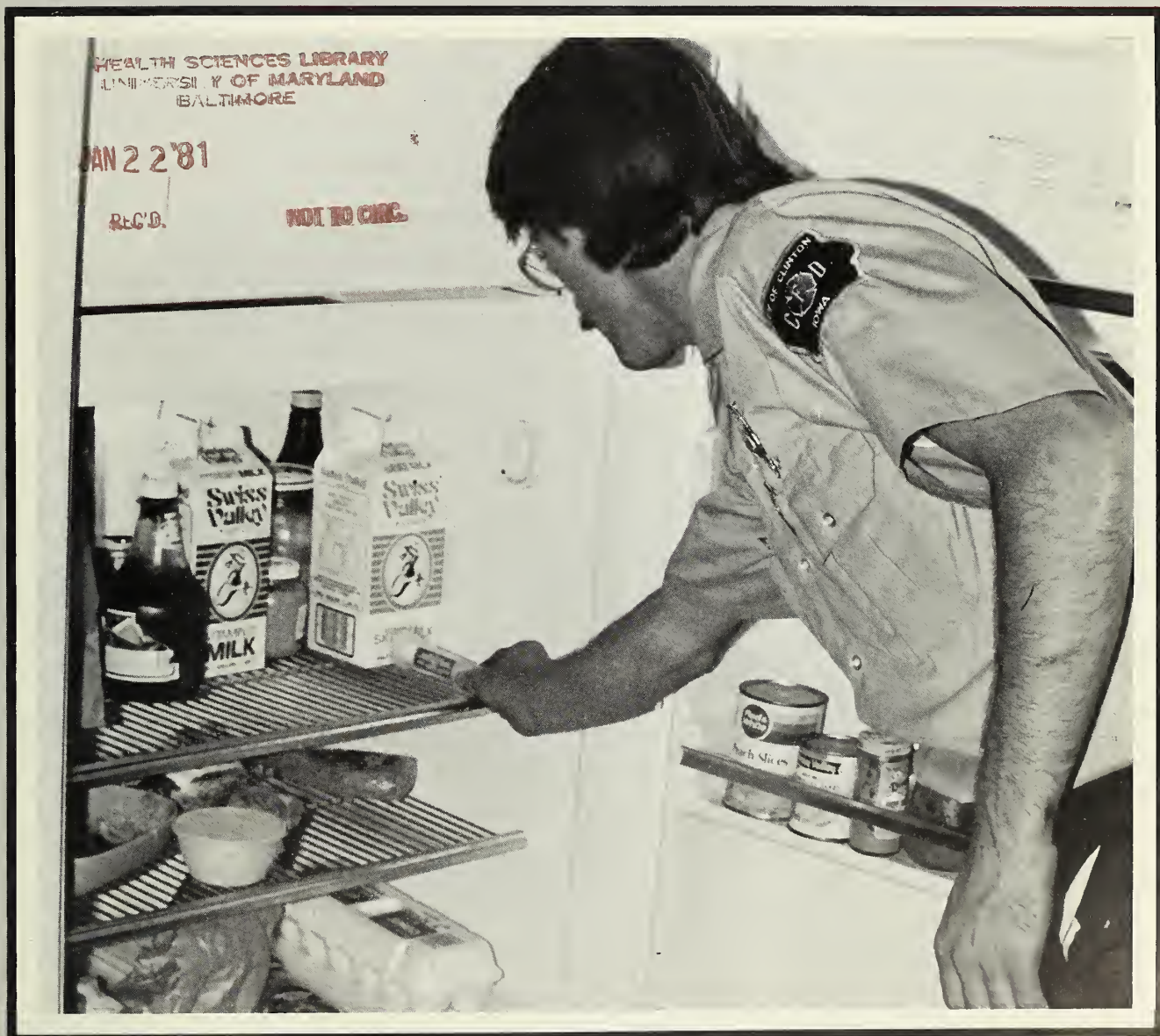


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JOURNAL OF THE **IOWA**
medical
SOCIETY



1981

half-life

Just one built-in advantage

Ensures smooth therapeutic effect even if a dose is missed The relatively longer half-life of Valium® (diazepam/Roche) has important clinical and pharmacological implications. Steady-state levels generally are reached within 5-7 days with no further accumulation. At this plateau, the patient benefits from the consistent, steady response you expect. Sharp blood level variations, frequently attributed to agents with a short half-life, do not appear with Valium.

Avoids sudden symptom breakthrough

Once steady-state levels are achieved, sudden reemergence of symptoms is unlikely. Diazepam and its active metabolites exhibit overlapping half-lives that are advantageous not only during therapy but especially when pharmacologic support is discontinued.

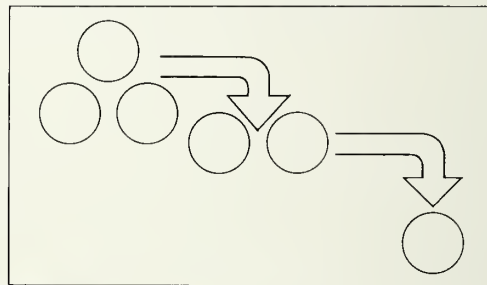
Elimination rates are gradual with Valium and thus provide a compatible adjustment interval for

the patient. In comparison, blood levels of short-acting agents with inactive metabolites decrease more rapidly and are more likely to be associated with withdrawal symptoms if medication is stopped abruptly.* With Valium unwanted effects other than drowsiness or ataxia are rare. Patients should be cautioned about driving and advised to avoid alcohol.

Tapers naturally; complements gradual dosage reduction at discontinuation

When any psychoactive medication is discontinued, it is good medical practice to gradually reduce the dosage. From your own experience you know this is rarely necessary after a short course of Valium therapy, but for patients on extended therapy, gradual reduction of dosage is advisable. This regimen, along with the self-tapering feature of Valium, provides a smooth transition to independent coping.

*Sellers EM: *Drug Metab Rev* 8(1):5-11, 1978



*in the management of
symptoms of anxiety*

Valium®
diazepam/Roche
2-mg, 5-mg, 10-mg scored tablets

*effective therapy through
efficient pharmacodynamics*

Before prescribing, please see summary of product information on next page.



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JANUARY 1981/ VOLUME 71 NUMBER 1

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ABOUT THE COVER — The Vial of Life program operates in several Iowa communities. One is co-sponsored by St. Joseph Mercy Hospital in Clinton with its Auxiliary. Vials to cover disposable syringes are converted to information receptacles and placed appropriately in refrigerators of senior citizens, handicapped persons, etc. Medical and other important info is inserted into the Vial and a red identification seal is placed on the refrigerator door. Rescue personnel are keyed to check for this information. A representative of the Clinton fire department is pictured on the cover as he locates a Vial of Life.

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NEWS/PRODUCTS, PROGRAMS, ETC.

Information on various products, programs, etc., is received regularly by the IMS JOURNAL. Here are short items sifted from the mail by the Scientific Editor. A reference to a specific product is not intended to suggest any particular endorsement. Additional information on any entry may be obtained by contacting the IMS JOURNAL.

GUAIFENESIN IN NEW FORM — The Breonesin brand of guaifenesin expectorant in soft gelatin capsules has been introduced by Breon Laboratories. Each Breonesin capsule has 200 mg of guaifenesin, equivalent to 2 teaspoons of the liquid expectorant. Dosage recommended is one or two capsules every 4 hours. The capsules are claimed to be as effective as the liquid form and contain no alcohol.

DRUG VOLUME — A new, fully cumulative edition of *USAN and the USP Dictionary of Drug Names* is available. The new 501-page, 8" x 11" edition has more than 15,000 entries, exclusive of cross-references and the appendices. All *USAN* released from June 15, 1961, when the U. S. Adopted Names program began, through June 15, 1980, are included.

USAN are adopted by the United States Adopted Names Council, co-sponsored by the American Medical Association, the American Pharmaceutical Association, and the Pharmacopeial Convention, and with participation by the U. S. Food and Drug Administration.

Orders for the new edition of *USAN/USP-DDN* should be addressed to the *USAN* Division, USP Convention, Inc., 12601 Twinbrook Parkway, Rockville, Maryland 20852. The price remains the same as for last year's edition: \$19.50 per copy, with quantity discounts for 11 or more copies.

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JOURNAL OF THE IOWA MEDICAL SOCIETY

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ABOUT THE COVER — This month's cover directs attention to a new continuing medical education opportunity contained in this issue of the IMS JOURNAL. You are encouraged to complete the quiz shown on the orange insert and return it according to the instructions to earn one hour of Category I CME credit. The project is a joint effort of the Iowa Foundation for Medical Care, the University of Iowa College of Medicine and the IMS.

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ABOUT THE COVER — At the 1981 American Medical Association National Leadership Conference (February 13/14), the Iowa Medical Society received a plaque recognizing the fifth consecutive year in which Iowa physicians have exceeded their previous year's level of AMA MEMBERSHIP. Shown on the cover is IMS President-elect John H. Kelley, M.D., left, accepting the plaque from AMA President Robert B. Hunter, M.D., Sedro Woolley, Washington. The smaller photo is of the plaque. **COVER PHOTO CREDIT:** Joe Fletcher, American Medical Association

Valium® diazepam/Roche

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Dosage: Individualize for maximum beneficial effect. **Adults:** Anxiety disorders, symptoms of anxiety, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed, adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. **Geriatric or debilitated patients:** 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) **Children:** 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

Supplied: Valium® (diazepam/Roche) Tablets, 2 mg, 5 mg and 10 mg—bottles of 100 and 500; Tel-E-Dose® packages of 100, available in trays of 4 reverse-numbered boxes of 25, and in boxes containing 10 strips of 10. Prescription Paks of 50, available in trays of 10.



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JOURNAL OF THE Iowa medical SOCIETY

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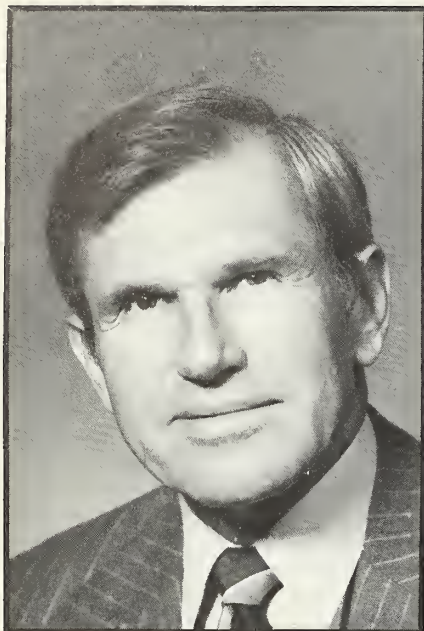
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ABOUT THE COVER — The long-standing Iowa preceptor program is shown in action. Junior medical student Curtis Hanson from Villisca examines a youthful patient under the watchful eye of Preceptor Carlyle C. Moore, M.D., Emmetsburg. Junior students must take a 2-week preceptorship in primary care. A number return for more study in the senior year. Elsewhere in this issue recognition is extended to Iowa preceptors. Also, this month's In The Public Interest contains preceptee comments on their experiences. **COVER PHOTO:** Jane E. Whitmore, Emmetsburg Publishing Company



PRESIDENT'S PRIVILEGE

WE TALK A LOT in our daily conversations about trust. We probably are prone to speak more about its absence than presence. We are apt to conclude that trustworthiness as a human trait is less conspicuous than it was in earlier days.

We go to our mechanic trusting him to do our repair work. We expect conscientious service. We expect lasting craftsmanship. And we expect the charge to be fair — in line with the time spent and the materials used. When these expectations are met we frequently take it for granted.

When the results and the costs are off the mark we express our criticism often and emphatically. Such expression tends to foster a belief that providers of services or products are out to take an unsuspecting public. This type of thinking promotes distress between the professions.

A mechanic has been used for illustrative purposes, but we could use a physician just as easily. It is understandable that greater expectations are present where personal health is involved. The need for trust and understand-

ing is far more important in the doctor-patient context. We need to do all possible within our individual practices and collectively within our profession to create a climate of openness and trust among ourselves, our patients, and other professionals. By doing so, we can set the kind of example expected from us.

The practice of medicine is truly the ultimate in one human being's service to another. It should be undergirded by trust. It is the kind of service relationship that must emanate from mutual respect and confidence. It must emerge from the human will and not from regulatory edict or fear. Please think about this.

Please let me finish these comments, too, by acknowledging this University issue. We are grateful for the excellent spirit of cooperation which exists between the College of Medicine and the Society.

William R. Bliss, M.D.

William R. Bliss, M.D.

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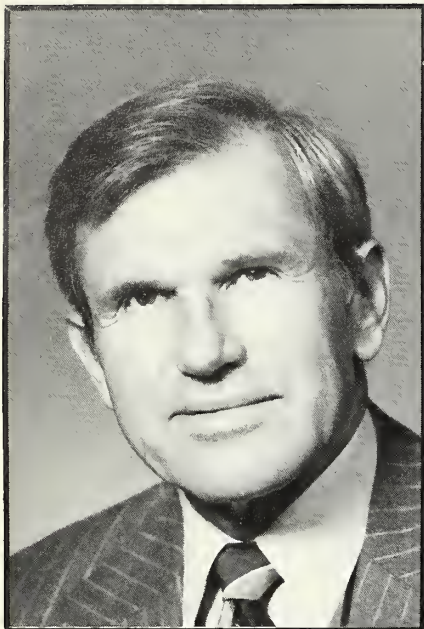
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ABOUT THE COVER — Borrowing on the old cliché, "Everything's Up to Date in Kansas City," this month's cover invites Iowa physicians to attend the 1981 IMS Scientific Session June 24 to 26 at the Alameda Plaza. The program for the Scientific Session appears on pages 192-193 of this issue. You are encouraged to consider this continuing medical education event.



PRESIDENT'S PRIVILEGE

THIS WILL be my last time to fill this space. I have appreciated the opportunity to comment. As is the case with most interesting experiences, my year as IMS president has gone quickly. Thanks to all for the high level of interest and support.

My concluding thoughts this month tend to parallel what was said in April about the need for physicians to be fully trustworthy. In this swan song, I would carry the theme a step further by underscoring the importance of responsibility within medical ranks.

Let me illustrate.

Nationally, through the American Medical Association House of Delegates, the profession has spoken in favor of eliminating federally mandated utilization review. Putting it simply, the AMA House has called for repeal of the Professional Standards Review (PSRO) Program. In step with this desire has come an announcement from the Administration of its plans to phase out PSRO by 1983.

So, if PSRO, as statutorily required, is cast to the winds, what next? Few physicians will argue against the need for assuring quality care; this was and presumably is the underlying intent of PSRO — even though cost restraint has become a more conspicuous mission. If PSRO is dismantled, does not the medical profession need to come forward with a voluntary alternative?

Here is where the element of responsibility may be tested. How does the profession act responsibly — in the absence of any federal mandate — to make sure the care delivered to Iowans is of high quality?

Various honest and legitimate opinions will come to bear on this question in the ensuing months. Such discussion is on tap to occur during the 1981 IMS House of Delegates.

Matters of quality assurance at the community and state levels demand leadership from the medical profession. We have the responsibility to furnish this leadership on a conscientious basis.

William R. Bliss, M.D.

William R. Bliss, M.D.

P.S. Your attention is called to information elsewhere in this issue about the 1981 IMS Scientific Session. It'll be a fine time in Kansas City. Please join us.

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ABOUT THE COVER — The Ronald McDonald House is expected to open this month in Des Moines. It will provide housing for families of certain seriously ill hospitalized children. The cover picture shows the structure located near Iowa Methodist Medical Center. In the photo left to right are Guy Fowler, vice-president, Iowa Methodist Medical Center; Mrs. Lis Spoerl, president, Children's Oncology Services of Iowa; Stephen C. Elliott, D.O., pediatric hematologist-oncologist. For more information see Questions/Answers feature on page 235. Photo Credit: Iowa Methodist Medical Center.

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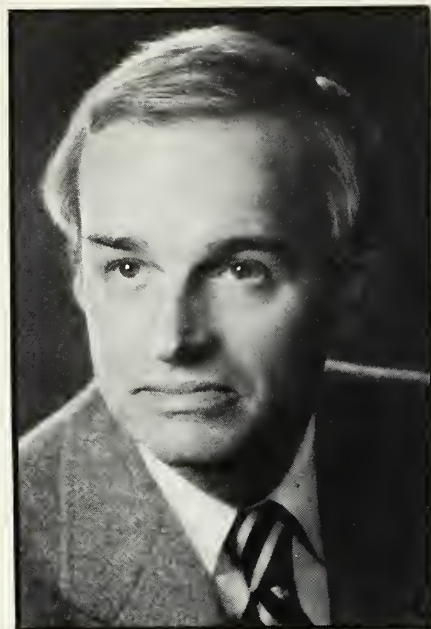
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PRESIDENT'S PRIVILEGE



IT'LL BE MY PLEASURE to say a few words in this space in the coming months. I hope we can select topics/issues sufficiently provocative to gain your interest.

First, I appreciate being president of the Iowa Medical Society. I note since 1970 this position of medical leadership has been filled by physicians from nine Iowa communities. This is a healthy geographical distribution. I am honored to follow these colleagues and all of our earlier predecessors.

Let me share brief thoughts on the recent IMS House of Delegates. It was a busy two-day session. The interest and participation seemed notably higher than in other recent years. There was a good volume of business (23 resolutions) on a variety of timely subjects. There were multiple candidates for several offices which added interest.

Maybe all IMS members should be required to observe (and even take part in) at least one session of the House of Delegates. Such an

obligation would increase the level of understanding and appreciation for what medicine does organizationally in the interest of the public and the profession.

These preceding comments are directed more at the form and process of medical government than at the actual substance of this year's meeting. Important issues were debated and acted upon in May. Key among our 1981 policy decisions were ones having to do with medicine's relations with those with whom we work in providing care to Iowans. Our course for the year ahead will most assuredly involve more looking for ways to fashion an optimum environment for delivering health care.

John H. Kelley, M.D.

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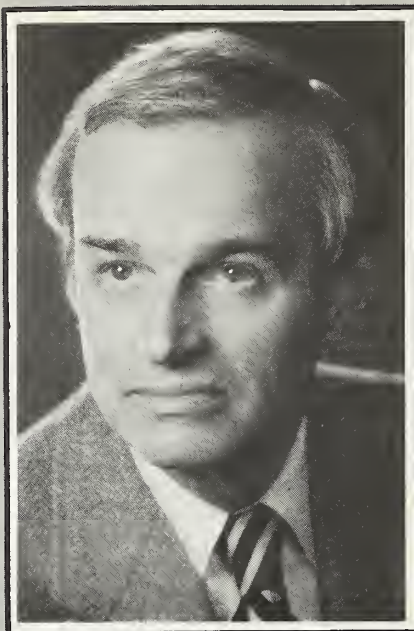
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FACES ON THE COVER — The 1981 IMS House of Delegates involved several hundred people. Some are pictured on the cover. Upper left shows Dr. and Mrs. Alan Nelson of Salt Lake City, Utah; he's an AMA trustee. Upper middle, retiring Auxiliary President Mary Ellen Kimball gives House report. Upper right, A. M. Dolan, M.D., Waterloo, smiles despite unsuccessful bid for election as IMS trustee. Lower left, U.S. Senator Roger Jepsen speaks briefly to the delegates. Lower right, Governor Ray receives 1981 IMS Sanford Award.

PRESIDENT'S PRIVILEGE



ACCORDING TO THE 1981 membership poll conducted by the Iowa Medical Society, cost containment is the medical care issue that occupies the highest priority among physicians. There is no question but that the general public shares this view. Hopefully, improved utilization review and out-patient procedures will help to control cost escalation here in Iowa.

Those who are concerned about escalating health care costs cite the fact that we are now spending 9 or 10% of our gross national product on health care whereas only 10 years ago this figure was closer to 6%. The implication is that health care costs have escalated much faster than the economy. Health care costs have escalated faster than inflation, but the magnitude of escalation has been due, in part, to two factors that are largely overlooked.

In the first place, whoever said there is any optimum percentage of the GNP that should be assigned to health care. As our population ages and medical science develops, there is no question in my mind that health care costs may well ultimately take 15% of the GNP. Anyone intimately involved in the rapid developments being made in each medical specialty will recognize this may be a conservative estimate. With a lower birth rate and an aging population, a greater stress will be placed on the value of good health. This is as it should be. This is

our mission. We must not compromise it to health planners who may be overly cost conscious.

Seventy percent of health care costs, particularly hospital costs, represent salaries and wages. We all will have to admit that hospital personnel are not highly paid. They are being asked to perform more and more skilled procedures and their training is becoming more complex. We expect and need competent people to help us in caring for the sick. The cost of qualified personnel with the highly technical skills needed to assist in the care of the sick will escalate far faster than inflation. This is a significant factor in the escalation of health care costs which cannot be compromised.

In summary, when we meet with businessmen and others interested in controlling health care costs, we must recognize we represent our patients. They expect us to see to it that they receive the best care our modern technology can afford and they trust us not to compromise their care for short term goals.

John H. Kelley, M.D.

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ABOUT THE COVER — Thomas "Pinky" McDonnell, right in the picture, is the first Iowan to be named Handicapped American of the Year by the President's Committee on Employment of the Handicapped. Shown sharing a smile with McDonnell is his physician, J. E. O'Donnell, M.D., of Clinton, who offers a Point of View on McDonnell on page 322 of this issue. PHOTO COURTESY OF Jerry Dahl of the Clinton Herald.

Valium®^{IV} diazepam/Roche

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Management of anxiety disorders, or short-term relief of symptoms of anxiety. Anxiety or tension associated with the stress of everyday life usually does not require treatment with an anxiolytic. Symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology; spasticity caused by upper motor neuron disorders; athetosis; stiff-man syndrome; convulsive disorders (not for sole therapy).

The effectiveness of Valium (diazepam/Roche) in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma, may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication, abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms similar to those with barbiturates and alcohol have been observed with abrupt discontinuation, usually limited to extended use and excessive doses. Infrequently, milder withdrawal symptoms have been reported following abrupt discontinuation of benzodiazepines after continuous use, generally at higher therapeutic levels, for at least several months. After extended therapy, gradually taper dosage. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed, drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other anti-depressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

The clearance of Valium and certain other benzodiazepines can be delayed in association with Tagamet (cimetidine) administration. The clinical significance of this is unclear.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice, periodic blood counts and liver function tests advisable during long-term therapy.

Dosage: Individualize for maximum beneficial effect. **Adults:** Anxiety disorders, symptoms of anxiety, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. **Geriatric or debilitated patients:** 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) **Children:** 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

Supplied: Valium® (diazepam/Roche) Tablets, 2 mg, 5 mg and 10 mg—bottles of 100 and 500; Tel-E-Dose® packages of 100, available in trays of 4 reverse-numbered boxes of 25, and in boxes containing 10 strips of 10, Prescription Paks of 50, available in trays of 10.

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JOURNAL OF THE Iowa medical SOCIETY

SEPTEMBER 1981 / VOLUME 71 NUMBER 9

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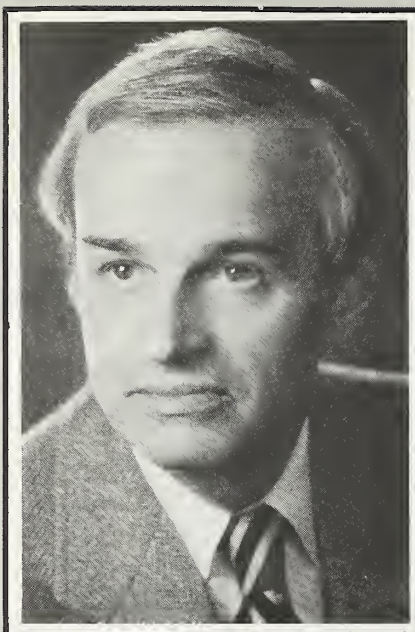
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ABOUT THE COVER — This month's cover calls graphic attention to the topic studied by Iowa hospitals through the Iowa Foundation for Medical Care. Along with the study report readers will find a brief quiz which may be completed and returned to earn one hour of Category I CME credit. This is the second such CME opportunity provided in the IMS JOURNAL.

PRESIDENT'S PRIVILEGE



IN AUGUST a news feature in the *Des Moines* Sunday Register analyzed the mail received by an Iowa lawmaker during the 1981 General Assembly. The lady legislator reportedly had 850 letters and other printed communications land in her mail box during the 18-week session. This mail was categorized among a variety of senders and prompted the northern Iowa Republican to comment, "There's not much point in writing to me if you live outside my district."

The point is well taken. Legislators owe main allegiance to their constituents. They must weigh most heavily those views which come from their home territory. The legislator called it "a free vote" when no constituent reaction or comment was received.

The "free vote" circumstance should not be allowed to happen often. I emphasize this particularly when it comes to physicians and medical care issues. When an important legislative proposal impacts on the public health or the manner of delivering care we should not let the vote come without communicating our views to our senator and representative.

These preceding comments are pertinent

right now because the Iowa Medical Society is embarking this month on a series of briefings around the state. They have as a goal to promote open and regular communication between legislators and their physician constituents. The series will include 12 evening meetings hosted by the IMS to foster personal discussion of key medical topics. The project is meant to be a catalyst to stimulate a continuation and expansion of information passage between physician and legislator. Most often, the legislators appreciate our expertise and take seriously our position on a legislative proposal.

This 1981 IMS series will also give participants a chance to look at the new reapportionment plan to see how their districts may have been revamped. It should be a stimulating time!

A handwritten signature in dark ink, appearing to read "John H. Kelley". The signature is fluid and cursive, with a large, sweeping initial "J".

John H. Kelley, M.D.

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JOURNAL OF THE IOWA MEDICAL SOCIETY

OCTOBER 1981 / VOLUME 71 NUMBER 10

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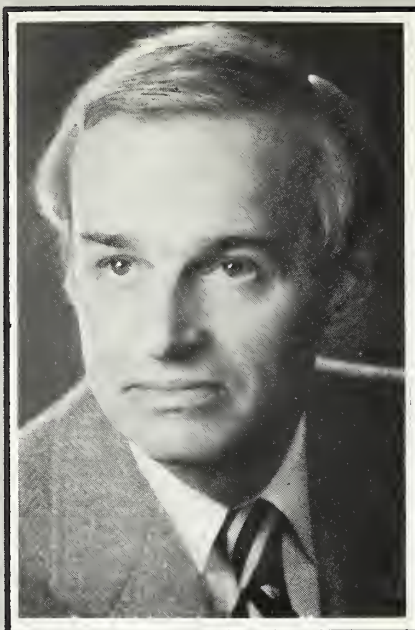
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ABOUT THE COVER — The cover picture directs graphic attention to the principal editorial thrust of this issue — the Iowa Medical Society Assistance Program for Troubled Physicians. As indicated, the IMS APTP is here to help. Thus, in the spirit of helping, we offer the content of the October IMS JOURNAL to inform Iowa physicians about the APTP and encourage its use when circumstances call for it.

PRESIDENT'S PRIVILEGE



YOU MAY NOT have thought of it quite in this light. Ten out of 10 Iowa physicians pay their annual \$40 licensure fee to the State Board of Medical Examiners. And 9 out of 10 of these Iowa physicians pay \$275 in professional dues to the state medical society.

A reasonable portion of these combined monies goes to help assure both the public and the profession that high quality medical care is delivered to the people of Iowa.

It's quite appropriate to say the Iowa Medical Society has supported the expanding (through statutory/regulatory extensions) role of the Board of Medical Examiners. The capacity of the Board to discharge licensure/surveillance duties has increased substantially in recent years. One obvious and major example is the requirement that continuing medical education activity be reported. Special commendation is due the Board for its conscientious attention to assigned tasks.

Just as significant as the BME expansion is recent implementation by the Iowa Medical Society of its Assistance Program for the Troubled Physician. Here probably is one of the best professional helping hands to come along. It seeks to reach out to help in situations, which, if addressed early, may eliminate future attention by the BME.

Dr. Hormoz Rassekh and his colleagues on the IMS Committee on Assistance Program for Troubled Physicians are to be congratulated for the thoughtful and deliberate blueprinting of this program. It is operative and serving effectively. It awaits use when necessary.

Our annual investment, as noted at the outset of these comments, is not insignificant. Neither though are the dividends which may come to you and me.

A handwritten signature in cursive script, reading "John H. Kelley".

John H. Kelley, M.D.

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NOVEMBER 1981 / VOLUME 71 NUMBER 11

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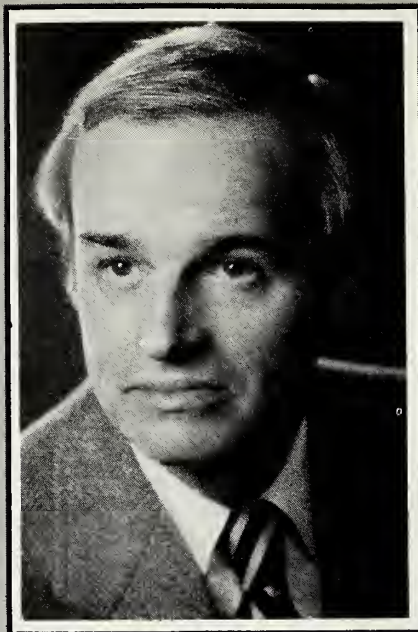
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ABOUT THE COVER — This November issue is given over to the subject of aging. Several articles are presented on the subject. A special insert is also included which offers tips to all older Iowans on how to live longer and better. Member physicians are encouraged to place the issue in patient reception areas.

PRESIDENT'S PRIVILEGE



BIBLICAL REFERENCES to age suggest that longevity was the vogue back then. Most famous of the long-livers was the early patriarch Methuselah, who is recorded to have lived 969 years.

How age computations were made among these scriptural ancestors is a matter of speculation and individual interpretation. However it was done, just contemplating such an existence in our modern frame of reference goes beyond all capacity.

Nonetheless, it is heartening to see the life expectancy of 20th century Iowans being extended. And it is correspondingly good to see the quality of life being improved in those years. As medical practitioners, our principal energy should be directed at these two objectives — extending life and making it better in so doing.

This November issue of the IMS JOURNAL is devoted almost totally to facts and thoughts about aging. You will note several references to the high proportion of elderly persons within our state population. That we have a sizable percentage (by comparison with other states) of older citizens residing inside our borders is good on the one hand; challenging on the other. As a consequence of these demographics, Iowa physicians need to make specific efforts to serve the health and well being of this special population category.

Of educational value to the elderly in this issue is the insert entitled, *Aging Well*. It focuses briefly and interestingly on how to do just that, *age well*. You are encouraged to read this issue, then put it in your reception area for your patients and others.

We have extra copies of the *Aging Well* insert if you would like a small quantity to make available to patients and others. An order form is provided adjacent to the insert.

So, at this time of Thanksgiving, we pause to count our blessings, not the least of which is the opportunity to know and serve many remarkably interesting and thoughtful older Iowans.

A handwritten signature in dark ink, appearing to read "John H. Kelley". The signature is fluid and cursive, with a large initial "J".

John H. Kelley, M.D.

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JOURNAL OF THE Iowa medical SOCIETY

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ABOUT THE COVER — The Convalescent Home for Children in Johnston (near Des Moines) is a handsome, new structure with excellent facilities. It is described briefly on pages 523 and 536. As superb as it may be as a building, its beauty comes really from the loving, caring people working inside. In the large cover photo, Occupational Therapist Cindy Kimball helps 3-year-old Sarah with a drink. In the small picture is Foster Grandfather Ken Robbins with 2-year-old Terri. Ken is a retired chef who volunteers his time four days a week.

WE'VE HELPED IMS PHYSICIANS WITH INSURANCE NEEDS SINCE 1955



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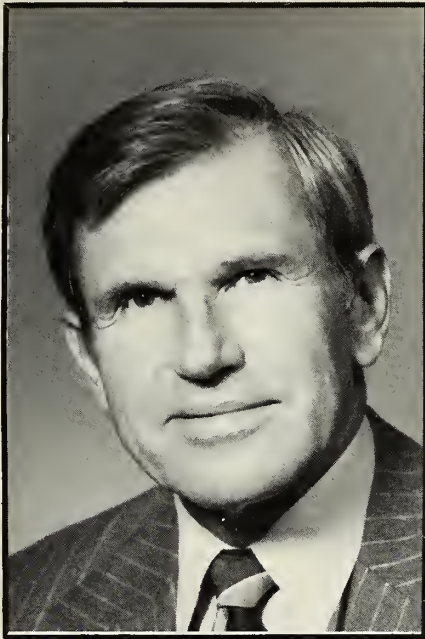
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PRESIDENT'S PRIVILEGE

THE FOURTH ANNIVERSARY of the Iowa Medical Society/Aetna Liability Insurance Program is occurring just now. Many of you can remember how this important program emerged out of chaotic conditions back in 1976. We have seen the program grow to where it now has nearly 1,200 physician participants, or about 48% of the eligible membership. While we are pleased at this success, we believe it healthy also that other insurance companies continue to provide a competitive market in Iowa.

The 1980 annual report of the IMS/Aetna program was given to the Medico-Legal Committee and the Executive Council in late November. At that time, the first premium increase — of 20% — was disclosed. Actually, the percentage increase since the program began is only 9%; that's because several premium reductions have occurred.

Perhaps the most disquieting aspect of the 1980 annual report was the indication that claims are heading upward in number and severity. This is occurring nationally and in Iowa. Up to cutoff time for the annual report (around August 1) the program's total number

of potential liability arisings stood at 96. In comments by Aetna officials, augmenting the annual report, the ominous word was that there has been an additional flurry of arisings since August. Of the 96 claims, better than two-thirds are in 5 specialty areas; these are, in order, family practice, general surgery, ob-gyn, anesthesiology and radiology.

Understandably, concern was expressed over any physician complacency which may have crept into our ranks these past 2 or 3 years of relative calm. Fifty-seven educational presentations were made in 1980 under the IMS/Aetna program. They were attended by over 1,000 Iowa physicians and 1,700 other health workers. We need to continue and intensify this kind of loss control and claims prevention activity in 1981. *It will benefit us all — regardless of insurer.*

William R. Bliss, M.D.

William R. Bliss, M.D.

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THINGS YOU SHOULD KNOW

ASSEMBLY CONVENES

Iowa lawmakers open the 69th General Assembly January 12. Republicans control both chambers: the House 58 to 42; the Senate 29 to 21. The scarcity of funds will make the appropriations process difficult. IMS energies will be directed at achieving the most adequate funding (for Medicaid, Board of Medical Examiners, Family Practice Residency Program) in view of the circumstances. Important reapportionment duties may be delayed by census problems. The IMS network of legislative contact physicians is set to assist the Society's Committee on Legislation in providing Iowa lawmakers with information on health-related matters.

RADIATION EQUIPMENT

By 12/1/80 close to 350 Iowa physicians and 115 hospitals had registered radiation emitting equipment with the State Department of Health. This registration program began 7/1/80. All possessors of such equipment, in health care, education, industry, government, etc., must comply. 90 of 166 x-ray machines inspected as of 12/1/80 were under the control of physicians, with about 25% of the physician units reported to have major noncompliance items.

OSTEOPATHIC DEVELOPMENTS

The College of Osteopathic Medicine and Surgery in Des Moines has announced plans to change its name to the University of Osteopathic Medicine and Health Sciences. This is in line with further plans to institute a podiatry training program in 1982, and a physician's assistant training program this year. Also indicated is a pre-professional program for optometrists. The announcements were made in December.

CHANGE IN HSA APPROACH

5 subarea offices operated by the Iowa Health Systems Agency are being closed. Several have already closed; all will be phased out by May. IHSA officials stress that while this action will trim costs, services will remain appreciably the same. 5 community relations associates will serve from Des Moines to provide assistance similar to that which has emanated from the subarea offices. Also, an IN-WATS line (1/800/622-8214) is available for inquiries.

SEAT BELT USAGE

Favorable findings have been identified by the Iowa Seat Belt Advisory Council in its push to encourage use of infant/child restraints to protect youngsters five years of age and younger. Through Council impetus, many prenatal care classes in the state are providing information on restraint equipment; as a consequence there's been a good increase in the usage rate. The IMS is represented on this Council.

ROLE OPTION CONFERENCE

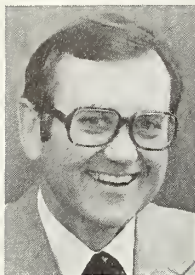
Future roles for hospitals will be the subject of a January 21/22 conference at the Hotel Fort Des Moines. The session is a joint project of the IMS, Iowa Hospital Association and the Iowa Health Systems Agency. The event is open to any interested physician. Please contact the IMS for information.

APPROVE SURGICAL LIST

The Iowa Foundation for Medical Care has approved a listing of medical and surgical procedures that generally can be performed on an outpatient or same day surgery basis. Use of the list will be made in tackling the question of high hospital admission rates in Iowa.

OMVUI OPINION FAVORABLE

Iowa physicians cannot be compelled by state law enforcement officers to assist them in their collection of evidence in a drunken driving case. This opinion was issued in December by the Attorney General's office. The opinion was sought by Representative Lawrence Pope at the request of the IMS; the 1980 House of Delegates asked for clarification on the matter.



QUESTIONS - ANSWERS

Richard M. Clock
Des Moines, Iowa

Mr. Clock is Assistant Vice President of Provider Affairs for Blue Cross and Blue Shield of Iowa. He provides brief explanation of the virtues of "paperless claims."

PAPERLESS CLAIMS

We are hearing the term "paperless claims" a lot. Briefly, what does it mean?

Blue Cross and Blue Shield of Iowa's paperless claims system is an automated billing method that allows health care providers to enter and transmit claims from an office terminal to our computer for processing overnight. In short, it's a method of claims filing that reduces paper flow and errors, yet provides quick claims payments and improved cash flow.

It works like this: A terminal in the physician's office is programmed to accept all information normally included on a paper claim. Equipment is available for purchase or lease. While they vary in sophistication and capability, all terminals are programmed to prompt the operator through the claims entering process and to edit errors along the way, much like a convenient banking terminal.

What are the major potential advantages of this type of program?

There are many. Currently, about 15% of the claims we receive are delayed from entering our processing system because they lack com-

plete information. Since the equipment in the physician's office is programmed to request all of the information it needs, fewer claims will be held up because of inadequate information. And, claims submitted should be more accurate since the information is edited as it is entered.

The paperless system also eliminates the mailing process (it requests the information from the terminal in the physician's office via telephone line), and this saves time in claims turnaround. Our computer can begin processing claims immediately after the information is polled from the physician's terminal, so we expect turnaround time to be substantially reduced. The results are faster claims processing and improved cash flow.

Finally, the use of specific diagnosis and procedure codes allows the physician greater control over the information submitted, since they can define the services actually performed.

Is there a minimum or maximum claims volume level for an office or clinic in the consideration of this concept?

We have found the concept applicable and affordable for a large percentage of the physicians in Iowa. The equipment offered varies from small office units to large multi-purpose service bureaus depending upon the needs and volume of claims submitted by the physician. Currently, we are working with four companies whose equipment is applicable to the system: IBM, IMPACT, Northwestern Bell Telephone Co., and Texas Instruments. While all of the equipment packages are suitable for claims entry and storage, some have other capabilities too. The system is cost-effective for almost any office that submits over 100 claims per month.

What are the basic requirements that must be met to implement this type of program?

A physician must either have the necessary equipment to enter, store and file the claims data or have an arrangement with a service bureau. Some hospitals or clinics who plan to use their own equipment must obtain the common format programming from Blue Cross and Blue Shield of Iowa. This format allows for terminal entry of Blue Cross, Blue Shield, Med-

(Please turn to page 31)

HERE'S MSIS-200

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January 1981 / 9

VOX DOCS

Please take a look at this month's Vox Docs question. It's below! Give us your answer. Send it to IMS JOURNAL, 1001 Grand Avenue, West Des Moines, Iowa 50265. Last month's question and answer results are shown to the right with several of the comments we received printed below.

"Fewer governmental regulations will be forthcoming; less likelihood of socialized medicine; an attempt will be made to cut excessive government spending." — *Donald W. Todd, M.D., Guthrie Center*

"The voters seemed to indicate a desire for less government spending, less inflation and less regulation, and this should put an indefinite hold on plans for national health insurance." — *Louis W. Banitt, M.D., Ames*

"We will see a more realistic approach with greater emphasis on the private sector." — *Robert T. Brown, M.D., Des Moines*

"I predict massive new government programs will be curtailed and some present programs reduced. However, the coalition of management and labor, if it comes to fruition, will

LAST MONTH'S QUESTION —

How do you see the outcome of the elections in terms of impact on medical care delivery over the next several years?

Will tend to improve circumstances 80%

Undesirable changes are likely

Impossible to tell 20%

boost HMOs as well as deductibles and co-payment insurance." — *John W. Rhodes, Sr., M.D., Pocahontas*

"There will be a shift from 'cost containment' (low cost medical care with little regard for quality) to 'cost effectiveness' (quality care at least cost)." — *Arthur L. Sciortino, M.D., Council Bluffs*

"When it comes to political management of health legislation there is not a great deal of difference between parties. There should be a more moderate approach with the incoming administration. However, one group seems to be as receptive to political maneuvering as the other." — *Richard Rogers, D.O., Eldora*

JANUARY QUESTION FOR IOWA PHYSICIANS

The American Medical Association has announced a major program on cost effectiveness for 1981. It will emphasize promotion of state, county and specialty society cost containment efforts. Are you willing to share individually in this further and stepped-up non-governmental program to restrain the increase in medical care costs?

- ☐ YES
☐ NO
☐ DON'T KNOW

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tion-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions) reported following discontinuation of the drug.

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Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude ataxia, oversedation, confusion (no more than 2 capsules/day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacology of agents, particularly potentiating drugs such as MAO inhibitors, phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions reported in psychiatric patients. Employ usual precautions in treating anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation; reported very rarely in patients receiving the drug

and oral anticoagulants; causal relationship not established.

Adverse Reactions: No side effects or manifestations not seen with either compound alone reported with Librax. When chlordiazepoxide HCl is used alone, drowsiness, ataxia, confusion may occur, especially in elderly and debilitated; avoidable in most cases by proper dosage adjustment, but also occasionally observed at lower dosage ranges. Syncope reported in a few instances. Also encountered: isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent, generally controlled with dosage reduction; changes in EEG patterns may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice, hepatic dysfunction reported occasionally with chlordiazepoxide HCl, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax typical of anticholinergic agents, i.e., dryness of mouth, blurring of vision, urinary hesitancy, constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.


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WARNINGS:

Drug dependence: Empirin with Codeine can produce drug dependence of the morphine type and, therefore, has the potential for being abused. Psychic dependence, physical dependence, and tolerance may develop upon repeated administration of this drug and it should be prescribed and administered with the same degree of caution appropriate to the use of other oral, narcotic-containing medications. Like other narcotic-containing medications, the drug is subject to the Federal Controlled Substances Act.

Use in ambulatory patients: Empirin with Codeine may impair the mental and/or physical abilities required for the performance of potentially hazardous tasks such as driving a car or operating machinery. The patient using this drug should be cautioned accordingly.

Interaction with other central nervous system (CNS) depressants. Patients receiving other narcotic analgesics, general anesthetics, phenothiazines, other tranquilizers, sedative-hypnotics, or other CNS depressants (including alcohol) concomitantly with Empirin with Codeine may exhibit an additive CNS depression. When such combined therapy is contemplated, the dose of one or both agents should be reduced.

Use in pregnancy: Safe use in pregnancy has not been established relative to possible adverse effects on fetal development. Therefore, Empirin with Codeine should not be used in pregnant women unless, in the judgment of the physician, the potential benefits outweigh the possible hazards.

PRECAUTIONS:

Head injury and increased intracranial pressure: The respiratory depressant effects of narcotics and their capacity to elevate cerebrospinal fluid pressure may be markedly exaggerated in the presence of head injury, other intracranial lesions or a pre-existing increase in intracranial pressure. Furthermore, narcotics produce adverse reactions which may obscure the clinical course of patients with head injuries.

Acute abdominal conditions: The administration of Empirin with Codeine or other narcotics may obscure the diagnosis or clinical course in patients with acute abdominal conditions.

Allergic: Precautions should be taken in administering salicylates to persons with known allergies: patients with nasal polyps are more likely to be hypersensitive to aspirin.

Special risk patients: Empirin with Codeine should be given with caution to certain patients such as the elderly or debilitated, and those with severe impairment of hepatic or renal function, hypothyroidism, Addison's disease, prostatic hypertrophy or urethral stricture, peptic ulcer, or coagulation disorders.

ADVERSE REACTIONS: The most frequently observed adverse reactions to codeine include light-headedness, dizziness, sedation, nausea and vomiting. These effects seem to be more prominent in ambulatory than in nonambulatory patients and one of these adverse reactions may be alleviated if the patient lies down. Other adverse reactions include euphoria, dysphoria, constipation, and pruritus.

The most frequently observed reactions to aspirin include headache, vertigo, ringing in the ears, mental confusion, drowsiness, sweating, thirst, nausea, and vomiting. Occasional patients experience gastric irritation and bleeding with aspirin. Some patients are unable to take salicylates without developing nausea and vomiting. Hypersensitivity may be manifested by a skin rash or even an anaphylactic reaction. With these exceptions, most of the side effects occur after repeated administration of large doses.

DOSAGE AND ADMINISTRATION: Dosage should be adjusted according to the severity of the pain and the response of the patient. It may occasionally be necessary to exceed the usual dosage recommended below in cases of more severe pain or in those patients who have become tolerant to the analgesic effect of narcotics. Empirin with Codeine is given orally. The usual adult dose for Empirin with Codeine No. 2 and No. 3 is one or two tablets every four hours as required. The usual adult dose for Empirin with Codeine No. 4 is one tablet every four hours as required.

DRUG INTERACTIONS: The CNS depressant effects of Empirin with Codeine may be additive with that of other CNS depressants. See WARNINGS.



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Medical Manpower in Iowa: Surplus or Shortage?

PAUL M. SEEBOHM, M.D.

Iowa City, Iowa

"The number of physicians has increased with great rapidity so that now there is, in Germany, one doctor for every 2,000 people, and in large cities one for every 1,000. . . . In the entire United States there is already on the average one doctor for every 568 persons, in large cities there is frequently one doctor for every 400 or less, and in many small towns with less than 200 inhabitants each have two or three physicians apiece."

THIS IS not George Orwell 1984. It is Abraham Flexner 1910.

The Flexner Report opened an era of reform in medical education that lasted over 50 years. The principal effect was to train fewer physicians better. It is interesting the small town people at the turn of the century were still

Dr. Seebohm is executive associate dean of the University of Iowa College of Medicine and immediate past president of the Iowa Medical Society. He made these remarks November 19, 1980 at a meeting of officers of the Iowa Medical Society, Iowa Nurses' Association and Iowa Hospital Association.

GMENAC has produced much recent debate regarding physician manpower surpluses. Here is an informed review of the Iowa picture. It concludes that we must maintain our current production of medical graduates if shortage and maldistribution problems are to be addressed.

advertising for more physicians even in the face of what appeared to be an overage. Many were predicting the Flexner educational system might improve training of physicians, but that it would reduce their numbers in small towns. And indeed it did.

Whereas, Flexner found a surplus of ill trained physicians, the prediction in the next decade is for a surplus of over-trained physicians. That would be, if it comes to pass, a new experience for American medicine, and it is interesting to watch those who speak for medicine jockey for position. The so-called GME-NAC (Graduate Medical Education National Advisory Committee) Report has come forth as a voluminous and complex document which took 4 years and 4 million dollars to develop. It contains 100 recommendations.

THE SCANLON MEDICAL FOUNDATION/IOWA MEDICAL SOCIETY HAS DESIGNATED THIS ARTICLE
AS THE HENRY ALBERT SCIENTIFIC PRESENTATION FOR THE MONTH OF JANUARY 1981.

TABLE I
FACTS RE IOWA MANPOWER

-
- 10-year Percentoge Increase in Retention of U. of I. Medical Graduates in Iowa Residencies is 250%; From 102% in 1970 to 256% in 1979
 - 55% of Graduates of Iowa Family Practice Residencies Have Selected Iowa Practice Sites
 - Iowa Will Have to Replace 160 Physicians Per Year
-

Reactions to GMENAC have been many and varied. Some have said the forecasted increase in physicians will not be a surplus, others have complained the methodology is faulty. The American College of Surgeons claims it is biased in favor of primary care specialties and discriminatory against surgery. Another view is that we do not know what the 80's and 90's will bring, therefore we should continue full speed ahead and be prepared.

The GMENAC recommendation which has developed the greatest interest relates to the manpower projections. At the present and projected rate of production there will be 60,000 excess physicians in 1990; 130,000 excess physicians in 2000; and surpluses of physicians in 19 medical and surgical specialties. The Report recommends corrective measures be taken to cut the supply of physicians coming from U.S. and foreign medical schools.

Among the measures recommended in the GMENAC report are:

- A reduction of 10% (from 1978 levels) of first year students in medical schools.
- Restrictions on foreign medical graduates.
- Discontinuance of the Fifth Pathway for U.S. FMG's.
- Reduction in federal education assistance to U.S. students attending foreign medical schools.

At the graduate training level a reduction is proposed in the number of residency positions in over-supplied specialties. Incentives are advocated to encourage residents to enter shortage specialties. It is further recommended the number of physician's assistants and nurse-midwives in training be held to current levels.

In Iowa, we still have the doctor shortage mentality. It seems incredible after struggling to increase the production of physicians, in response to a crash program 10 years ago, that a crash program to go in the opposite direction should have to come so soon.

Considerable progress has been made in correcting the physician shortage and distribution problems in Iowa, but we still seem to have a way to go.

Among the opinions critical of the GMENAC Report is that it may well be true the nation as a whole is on a course that will produce too many physicians by 1990 and 2000, but this is not likely in our State, and that is the opinion I hold.

TRENDS IN IOWA

In Iowa, the College of Medicine increased first-year enrollment from 120 in the 60's to 175 in the mid-70's. Recognizing the association of geographic maldistribution of physicians with the rural character of the state, primary care training, especially in family medicine, was given a major emphasis in both undergraduate and graduate medical education.

The progressive decline in number of physicians (M.D.s and D.O.s) in Iowa was stopped in the mid-70's and net gains have occurred (72 in 1977, 78 in 1978, and 72 in 1979). In 1979, however, it took 241 new physicians entering practice to replace the 169 who left, thus producing a net gain of 72. In the case of family physicians and general practitioners the new physicians have barely equaled the losses from death and retirement in 1977 and 1978 and have fallen behind in 1979.

The correction of maldistribution, both geographic and specialty, is critical to the solution of the medical manpower problems in Iowa and most of the U.S. The programs in primary care are new, small, and still dependent upon political policy and fiscal support. Much of the progress made in attracting medical graduates into family practice has been the result of the increased enrollment in medical schools. This coupled with placing a limit on the residency training opportunities in the traditional specialties of medicine has fostered the expansion of training in primary care. Reducing medical school enrollments at this time could be expected to have a very negative effect on these programs, which are essential to the correction of the physician distribution problem.

PHYSICIAN PRODUCTIVITY

Changing physician productivity is another major factor in the evaluation of the adequacy of the net physician supply and in the determination of the net requirements for new

physicians. Generally, productivity is defined as the amount of service provided by a given physician over a given time period. Although there have been no definitive organized studies of physician productivity, there are trends in physician behavior which suggest more time is being spent with each patient, fewer patients are being seen per week, and the number of working hours per week is falling below 50. If such changes in productivity become widespread, the number of new physicians needed to replace their predecessors will have to be greater than 1 for 1. Estimates made of this productivity factor for family physicians suggest 3 new physicians will be required to replace 2 current physicians.

Although the expansion of the medical school system was stimulated by federal initiatives, it was actually carried out by state and community interests with a primary concern for correcting local shortage and maldistribution of physicians. Many of the state schools have instituted preferential admission policies for state residents, primary care preceptorships and community-based residency training programs designed to encourage the retention of physicians within their state. The effect of these programs has been to minimize the mobility of physicians and thus their out-of-state migration. We are seeing this now in Iowa.

In 1970 there were 102 graduates of the University of Iowa College of Medicine in residency training in Iowa compared to 256 in 1979, a growth in retention of 250%. 55% of the graduates of the Iowa family practice residencies select Iowa locations in which to practice, demonstrating the importance of the residency as a determinant of physician practice location. Even so, Iowa still needs to import physicians to replace the average loss of 160 physicians a year. In 1977, 231 M.D.s entered practice and 159 left for a net gain of 72. Slightly less than half of these entering physicians (99) had some part of their training in University of Iowa programs. The other half, who trained outside of the state, migrated to Iowa. As this trend for physicians to practice where they train progresses, Iowa will become more and more dependent upon Iowa trained physicians to replace those leaving practice (160) and keep up with population growth.

Reducing the medical class size could place Iowa in the position of needing to import

TABLE II
PHYSICIAN/POPULATION RATIO

CURRENT:
2.8 Million Population
3,155 Physician Population
112/100,000 Ratio
1990 PROJECTED:
3.0 Million Population
3,843 Physician Population
126/100,000 Ratio
PROJECTED NATIONAL RATIO:
242/100,000

physicians at a time of their declining mobility. It is well known that 85% of the primary care physicians trained in the West and the South are retained in those regions and less than 7% of physicians trained in the Northeast locate in the Middle West.

Iowa is in a good position to continue to meet the medical manpower needs of the state at this time. Reduction of enrollment now would put this state of independence into jeopardy.

CONCLUSION

Currently, Iowa has 2,800,000 people and 3,155 physicians for a 112 per 100,000 physician/population ratio. The net gain of 60-70 physicians each year for the past 3 years, if projected forward for 11 years, would give Iowa approximately 3,843 physicians in 1990. The population of the State is projected to be 3,088,197 in 1990 which would provide a physician to population ratio of 126 per 100,000. This concentration of physicians will still be 50% less than the projected national average of 242 per 100,000.

It is evident if Iowa is to maintain its momentum in correcting not only the shortage but the maldistribution of physicians in the next decade, it will be critically important to sustain the current enrollment of 175 students per year in the University of Iowa College of Medicine. The balance of the supply and demand of physicians is progressively becoming more and more of a regional problem, and whereas there may be an excess of physicians over demand in some parts of the country, particularly in the East, such is not occurring in Iowa, nor is it projected within the next decade.

A Point of View

PROPHYLACTIC ANTIBIOTICS & THE SURGEON

THE INTRAOPERATIVE use of systemic antibiotics, as a prophylaxis against wound infections, has an almost irresistible appeal to the practicing surgeon. Such an adjuvant fits neatly with our knowledge of the timetable by which invading microorganisms gain a foothold in the surgical incision. It requires about 8 to 12 hours for the cellular defenses of the body to be called up and arrayed against such an attack. It seems only common sense to saturate partially disabled tissues with an effective antibacterial agent during the time lapse, while the body is mustering its major counterattack. Indeed, the very blood and edematous tissue fluids of such a wound are thus seemingly made lethal to bacterial encroachment.

There is a further charm to such prophylactic antibiotic use: The onus of wound infection, anathema to any surgeon, is warded off by a new magic; or at least a failure of the scheme is forced to bear a portion of the stigma, should infection prevail. There is a certain air of almost embarrassment which pervades a surgical service when it must daily confront a disproportionate number of infected wounds. We read where wound infection rates in potentially contaminated incisions have now been diminished from a well over 20% to 6% by such a routine. This is truly wonderful — or is it?

Many surgeons operating on essentially similar patients have a wound infection rate of not more than 6% without the use of prophylactic

lactic antibiotics. While it is true that patient age, sex, economic status and general health are factors, the major difference is most likely the surgeon himself. Operating rooms are seldom managed in a democratic manner; as the captain of a ship, the surgeon's responsibilities include his entire environment. If he is content to ignore minor "breaks" in surgical technique, the whole operating team quietly falls into a disregard of important surgical principles. The surgeon, as the model, sets the tone and must expect nothing less than perfection; proper patient preparation; Halsted's principles as amplified by today's technical and mechanical aids; aseptic means of handling a potentially contaminated situation; and a true regard for Nature's reparative processes, which man cannot speed but can disrupt. In certain situations when infection is likely, or when its occurrence may be catastrophic, Nature's protective and reparative mechanisms may well be augmented by anti-bacterial prophylaxis. However, in the day-to-day management of surgical patients, a steadfast adherence to surgical principles is far more apt to yield a happy surgical result than all the antimicrobials that are currently available.

It has been aptly said that "for something to make a difference, it must make a difference." Prophylactic antibiotics have not made a difference in clean or clean-contaminated surgical wounds. Their usage should be restricted only to those cases in which postoperative infection seems a likely problem.

Dr. Owen Wangenstein has said that "antibiotics may convert a third-class surgeon into a second-class surgeon; but never a second-class surgeon into a first-class surgeon." I quote him in this respect not to identify individuals or schemes of treatment — just to make a point! — TOM D. THROCKMORTON, M.D., *Des Moines*

One, Two, Now Three Years — Training the 'Family Specialist'

PAUL M. PAULMAN, M.D.

Placed in historical perspective is the evolution of family practice training at Broadlawns Medical Center. The current 3-year training program is explained with the declaration that it is built on a strong foundation and is helping meet Iowa health care needs.

BROADLAWNS MEDICAL CENTER, Des Moines, Iowa is the site of a 3-year family practice residency program with 30 residents in training. This program has evolved from a highly successful prototype 2-year general practice residency program. For just over 50 years, Broadlawns has provided board-eligible family practitioners to help meet Iowa health care needs.

The January, 1967 issue of *Hospital Practice* contained an article entitled, "Training the 'Family Specialist.'"¹ It reviewed the 2-year general practice residency program at the then named Broadlawns Polk County Hospital. It described the technical aspects and philosophy of the program, and asked the question: "Could the 2-year general practice residency program at Broadlawns, and other hospitals, be expanded to meet the requirements of a 3-year training program for the family specialist?"

Even at that time one year of postgraduate training was recognized as inadequate for the

primary physician. The medical "knowledge explosion" and the increased emphasis on both quality care and improved physician education were cited as the chief reasons. For these reasons, a score of pilot 2-year general practice programs were established in the early 1960's across the United States. The Broadlawns 2-year program was established in 1962. It was unique in its offering of training in ob-gyn and surgery. The pilot program was considered one of the most successful and was the subject of a 30-minute educational film sponsored by the then American Academy of General Practice.²

In 1967, the Broadlawns residency program consisted of inpatient training in internal medicine, psychiatry, pediatrics, ob-gyn, and surgery, along with general outpatient clinics. In addition, the trainee had the opportunity to develop his own private practice. The resident followed his patients in an outpatient general practice clinic and managed their hospitalizations. The residents were encouraged, also, to follow obstetrical patients through antepartum, delivery and post-partum periods. The resident continued to care for both the mother and infant after discharge.

The Broadlawns program was a reasonable approach to a 2-year general practice residency. However, in the late 1960's, it was recognized that even 2 years of family specialist training was inadequate. Indeed, one of the first outlines of the basic philosophy of a general practice residency training program, and later, family practice, was published by Robert E. Carter, M.D., then director of medical education at Broadlawns.³

Dr. Paulman was chief resident in the Broadlawns family practice residency program when this paper was prepared. He is now in private practice in Albion, Nebraska.

NUMBERS NEEDED

The fact that increasing numbers of family specialists, or primary physicians, were, and are, needed is dramatically demonstrated by several studies. From 1931 to 1975, the United States population increased from approximately 123,886,000 to 212,200,000. During that time, the number of family practitioners and general practitioners declined from 112,116 to 51,270, and the number of specialists directly involved in patient care increased from 22,158 to 236,567. In 1974 (calculating a ratio of 1 family physician to 2,500 patients), there was a national deficit of 31,123 family physicians. On the other hand (calculating a ratio of 1 internist to 5,000 patients and 1 obstetrician-gynecologist to 11,000 patients), there were excesses in both of these specialty areas.⁴ Gaps exist in health care nationally, as can be observed by examining a map of Federal Health Manpower Shortage Areas. These areas, mostly rural and inner city, were previously served by the general practitioner. As the number of family and general practitioners declined, many patients were without good, comprehensive medical care, especially the 58 million living in rural areas. Regionalization of medical care and assumption of primary care responsibilities by other specialists compensated, in part, for this deficit.

It was soon recognized by the federal government and the public that even these steps would not fill the primary care "gaps." This determination was based on reports by concerned groups, such as the Citizens' Committee,⁵ that showed medical training programs were not producing primary physicians sufficiently trained to offer comprehensive care in several specialty areas. The primary or family physician was defined by the American Medical Association Council on Medical Education in July of 1969 as:

"One who [1] serves as the physician of first contact with the patient and provides a means of entry into the health care system; [2] evaluates the patient's total health needs, provides personal medical care within one or more health fields of medicine, and refers the patient when indicated to appropriate sources of care while preserving the continuity of his care; develops a responsibility for the patient's total care, including the use of consultants, within the context of his environment, including the community and the family or comparable social unit. In short, the family physician must be prepared to fill a

*unique and special functional role in the delivery of modern comprehensive health service."*⁶

To fill this need, family practice was recognized as a primary care specialty in 1969. It was a designation intended for physicians completing a comprehensive 3-year post-graduate training. And it was to replace 1-and 2-year programs. In addition, the family practice residency programs would be geared specifically to educate physicians capable of practicing in areas of greatest need. The 2-year general practice residency at Broadlawns became a 3-year family practice residency in 1971.

BROADLAWNS TODAY

Today, Broadlawns Medical Center is a 192-bed primary care facility in an expanded community of nearly 300,000 population. The hospital serves many of the area's medically indigent, and its active emergency department handles many of the county's medical and surgical emergencies. In the period from June 1976 to June 1977, the hospital had 6,001 inpatient discharges, 107,519 outpatient visits, 765 deliveries and 1,175 major and minor surgical procedures.

The 3-year family practice residency program at Broadlawns is tailored to train family physicians capable of providing primary care in varied practice settings. The program is affiliated with The University of Iowa College of Medicine and is a part of the family practice education network, which is made up of 7 other family practice residency programs throughout the state. The University of Iowa serves as a referral center for many of Broadlawns' patients who require secondary, or tertiary, care facilities and provides support to the program in many ways. Included is the "visiting professor" program (clinical instructors from various departments who provide clinical lectures, as well as informal inpatient and outpatient consultations in their specialty areas during day-long visits).

In addition to the 30 family practice residents and two one-year flexible interns training at Broadlawns, senior residents from The University of Iowa College of Medicine rotate on various services. These include medicine, obstetrics-gynecology and psychiatry, and medical and surgical sub-specialties as well. To general surgery residents from the Iowa Methodist Medical Center in Des Moines rotate through the respective departments at Broad-

lawns, functioning in a supervisory/teaching capacity. The faculty includes 14 full-time physicians (4 of whom make up the family practice staff), 12 part-time consultants and 281 volunteer attending staff physicians.

TRAINING OUTLINE

Training is provided by inpatient and outpatient rotations in accordance with established guidelines. During the first year of training, the resident rotates through inpatient and outpatient medicine, surgery, ob-gyn and pediatrics. One month is spent on inpatient psychiatry with 2 half-days per week in an outpatient psychiatric clinic. Two weeks each are given to an in-hospital elective and vacation. First-year residents begin to develop their own "private practice," selecting patients to be followed during the assigned half-day per week in the Family Health Center (model office). The second-year resident spends 3 half-days per week in the Family Health Center and rotates through the inpatient medicine, pediatrics, surgery, ob-gyn and psychiatric medicine services. Two months are reserved for electives and 3 weeks for vacation. Time during the third year is divided as follows: 5 half-days per week in the Family Health Center (including one month as clinic manager); one month is spent in a supervisory capacity on inpatient medicine, 2 months in off-campus preceptorships, and the balance of the year is set aside for medical and surgical sub-specialty (s)electives. There are 4 weeks of vacation in the final year of the residency.

The Family Health Center and the Family Practice Service at the hospital are essential parts of the training program and serve as a model for private practice in a group setting. The clinic was completed in 1973 at a cost of \$642,000 and serves as a model office. It is arranged into 4 office areas with examining rooms varying in furnishings; it includes x-ray and laboratory facilities. Ancillary personnel include a full-time clinic manager, psychologist and social worker, and a half-time dietitian. Patients are selected by the residents and are followed in the clinic. Upon graduation, the patients of the third-year residency class are assigned to the first and second-year residents, preserving continuity of care. Patients are seen by the residents on an outpatient basis with back-up from the family practice staff. Should a resident be absent, one of the other residents

sees the patient in much the same manner as a group practice. If a patient requires hospitalization, the resident admits the patient to the Family Practice Service and attends the patient under the supervision of one of the family practice staff. Consultation is readily available in all disciplines and sub-specialties upon the resident's request. One of the senior family practice residents (second or third-year) is on call after clinic hours to see family practice patients in the hospital Emergency Department as needed.

TEACHING PROVISIONS

Teaching at Broadlawns Medical Center is provided in various ways:

- From staff and affiliating senior specialty residents in informal consultations.

- Learning-by-doing under the supervision of staff, senior family practice residents and senior affiliating specialty residents.

- Mini-sessions: Informal teaching conferences presented by the residents during many clinical rotations.

- Through dealing with a myriad of medical problems in the busy outpatient/emergency area.

- Training in the Family Practice model office in the Family Health Center.

- Formal clinical lectures held every weekday, including a "morning report."

Family practice residents at Broadlawns are not trained to be semi-surgeons. While they do no major surgical procedures, such as herniorrhaphies or appendectomies, there is adequate opportunity to learn such procedures as cut-downs, vasectomies, and D&C's, etc. Valuable experience is gained in the initial management of major and minor trauma during time spent in the Emergency Department. Pre- and Post-operative care is stressed during surgical rotations, as well as diagnostic surgical skills.

SUMMARY

The conversion from a 2-year general practice to a 3-year family practice program at Broadlawns was due, in part, to the need for primary physicians capable of providing comprehensive medical care in several specialty areas. This program at Broadlawns is helping meet Iowa's health care needs in two major ways:

- (1) The hospital itself, with its 32 residents and interns, provides care to one of Iowa's few "inner-city" populations.

ONE, TWO, NOW THREE YEARS — TRAINING THE 'FAMILY SPECIALIST'

(Continued from page 17)

(2) Graduates of the 3-year program, who are board eligible in family practice, are practicing in many rural areas of Iowa. Since the program's inception in 1971, 17 of the 25 graduates of the 3-year program are practicing in Iowa. Of those 17, there are 15 practicing in communities of 25,000 or less. Of these, 1 is in a community of 15-25,000, 9 are in communities of 5-15,000 and 5 are in communities of fewer than 5,000 population.

Question: "Could the 2-year general practice residency program at Broadlawns, and other

hospitals, be expanded to meet the requirements of a 3-year training program for the "family specialist?"

Answer: Positive. After 12 years the family practice residency program is built on a strong foundation, has recently been accredited for 3 years, and is training board eligible family specialists to help serve Iowa's most urgent health care needs, both during training and following graduation.

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Phenothiazines Induced Keto-Acidosis

ALBERT KAPLAN, M.D.,
JENNIFER CRAWFORD, P.A., and
ROBIN HAMRE, B.S.
Mt. Pleasant, Iowa

This short case report is intended to make physician readers aware of potential problems which may emerge with the administration of large doses of Phenothiazines. The situation encountered here is reportedly not discussed in the medical literature.

A 17-YEAR OLD GIRL was admitted to the Mt. Pleasant Mental Health Institute on August 17, 1979 from a sister facility with acute severe Keto-Acidosis. Urinalysis revealed 4+ sugar and 4+ acetone. The blood sugar level was 310 mg/dl. The patient presented with nausea, dehydration, polydipsia, polyuria, emesis, pruritus vulvae, galactorrhea, amenorrhea and polyphagia. Some of these symptoms dated back 4-6 months, while others, such as nausea, dehydration and emesis, had been present only a few days.

Prior to admission the patient was receiving Thorazine 1,200 mg daily and Prolixin 100 mg intramuscular weekly.

There was no suspicion of diabetes mellitus on admission at the previous hospital where the patient had resided for approximately one year. Both urine and blood sugar levels were within normal limits. Moreover, a year earlier, the patient delivered a normal infant at The University of Iowa Hospitals, and the record

reveals no glycosuria and the fasting blood level was 79 mg/dl. The family history showed the mother of the patient to have had adult onset diabetes mellitus.

Our treatment was energetic and consisted of large doses of Insulin. As much as 110 units were administered the first 12 hours with the dosage reduced until she was taken off entirely on September 4. She was given large amounts of fluid orally. Her diet was reduced to 1500 calories to include large amounts of bulky low-caloric foods. All Phenothiazines and other antipsychotic medications were discontinued.

TABLE I
FASTING AND POSTPRANDIAL BLOOD SUGAR LEVELS

Date	Fasting	2 Hour PP
8-17-79 P.M.	310	
8-18-79 A.M.		664
8-19-79 A.M.	156	
8-23-79 A.M.	162	
9-04-79 A.M.	113	105
9-14-79 A.M.	97	91
10-1-79 A.M.	84	84
10-19-79 A.M.	91	118

As stated, the patient was continued on gradually decreasing doses of Insulin until her urine was sugar free and her fasting blood sugar level was normal. This goal was reached 7 days following admission. Her fasting blood sugar remained so for the following 3 months. The urine was checked 12 times every 24 hours during the acute phase. Table I shows the record of fasting and two hour postprandial blood sugar levels.

(Please turn to page 22)

Dr. Kaplan is director of medical services at the Mount Pleasant Mental Health Institute.

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COMMENTING EDITORIALLY

MARION E. ALBERTS, M.D.
SCIENTIFIC EDITOR

PET PEEVE PONDERINGS

MANY INDIVIDUALS make astute resolutions at the beginning of the new year. As food for thought for those still considering 1981 resolutions, I submit some of the *pet peeves* I often ponder. If any of these personal peeves should fit one or more of our readers, I hope you will not be offended, but rather will rise to the occasion and relieve me of further mental anguish by remedial actions.

- Physicians and nurses, in my opinion, show poor manners when they sit on the bed of the patient. Conversation with a patient should occur in a totally professional manner, certainly with a warm and cordial tone, but not so informally as to sit on the hospital bed. Furthermore, bed linens are a personal item to the patient and should not be soiled by whatever the physician or nurse sat upon previously.

STANDARDS FOR CPR

The 1979 National Conference on Cardiopulmonary Resuscitation and Emergency Cardiac Care developed revised standards for CPR and ECC. These are presented in the August 1, 1980 issue of JAMA. There are no major changes to

- Able-bodied, youthful physicians frequently park their automobiles in "no parking" or out patient parking zones at the hospitals. Parking lots are provided for physicians. Disrespect of parking regulations by a few physicians reflects on the medical staff as a whole. I have heard other hospital personnel say, "who do the doctors think they are?"

- Pharmacists should not allow drug salesmen to scan their prescription files to see what prescriptions are being written by given physicians. Certainly, these are privileged communications which pass from physician to pharmacist. Salesmen, do not indicate to me what you have learned from such peeking in the drugstore, for I may retaliate in my own way.

- I wish publishers of magazines and journals could work out an arrangement with the post office to protect the top and bottom copies of any bundle. I am upset to receive a fine publication with the outside pages torn by balancing wires and rough handling. I do not plan to change my name to avoid being at the top of the list.

- Why do parents make an appointment for one child and then bring two others along to be checked? They ask that the others be looked at "if you have time because they have been complaining about sore throats, too." True, it doesn't take long, but multiplying a couple minutes many times a day creates problems. It can be disruptive to others when you are trying to maintain a busy schedule.

None of these peeves is earthshaking, nor will their continuation alter my life significantly. At best, maybe, I have raised some thoughts on human relations worthy of reflection.

Happy New Year! — M.E.A.

the 1974 standards but some terms have been redefined and some procedures have been expanded.

These standards for CPR should be studied by all physicians, if for no other reason than more and more members of the general public are proficient in the principles and procedures of basic life support. CPR has become a part of our life, and the provision of this care may

* JAMA, 244:453-509, August 1, 1980.

Editorials

(Continued from page 21)

come from varied individuals in our society. Often the physician comes to depend on machines and other paraphernalia and feels inept or insecure with just basic support procedures. Advanced life support may be more appropriate to the physician's training and capabilities, but this basic support must be pro-

PRACTICAL PEDIATRIC FLOW RECORD

A Pediatric Flow Record (PFR) developed by the Cedar Rapids Family Practice Residency Program has received extensive national notoriety in recent months. The PFR is described in an article written by John S. Downing, M.D., and published in the April, 1980 issue of *RESIDENT AND STAFF PHYSICIAN* magazine. Dr. Downing is director of ambulatory pediatrics for the Cedar Rapids Medical Education Program.

The published article has also been de-

veloped initially when no adjunctive aids are available.

The guidelines and standards are very complete in providing the know-how of CPR and ECC for neonates, children and adults. Procedures for basic, as well as advanced, life support are succinctly outlined. Tables of drug indications and dosages are included. Finally, there is a discussion of the medicolegal considerations and recommendations.

Each and every physician should read — nay, study — this report, and retain the August issue of *JAMA* for continuing reference. — M.E.A.

veloped into a scientific exhibit and was presented at the 32nd Annual Scientific Assembly of the American Academy of Family Physicians in October.

The PFR was first developed by the Cedar Rapids Family Practice Residency Program in 1975 to promote and assist in the delivery of standardized care to pediatric patients. It has undergone annual updating and has received enthusiastic endorsement by the local hospital clinics and private physicians. It is described as one answer to the challenge of keeping complete and understandable pediatric charts.

Single copies of the summary article and PFR forms may be obtained on request to the JOURNAL OF THE IOWA MEDICAL SOCIETY.

PHENOTHIAZINES INDUCED KETO-ACIDOSIS

(Continued from page 19)

Insulin was discontinued September 4, 1979. All urine remained free of sugar for 3 months until she was transferred. The diet was: high carbohydrate; low fat; normal protein. This resulted in a weight loss of 7 pounds.

It is worth noting that the behavior of the patient required neither antipsychotic medication nor restraint during the 3 month stay. Her menses resumed their normal schedule.

It is our impression that this severe case of Keto-Acidosis was induced by large doses of Phenothiazines. We consider it worth reporting because we find no similar case in the litera-

ture. There have been many reports of the effects of Chlorpromazine on glucose metabolism producing glycosuria, hyper- and hypoglycemia, and several cases of diabetes associated with administration of Chlorpromazine. These cases were very mild and no previous reports indicate the occurrence of severe Keto-Acidosis with life-threatening clinical manifestations.

This case report is intended to serve to remind those who administer large doses of Phenothiazines to be aware of its potential dangers.

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OUR MAN ON EDUCATION

RICHARD M. CAPLAN, M.D.

MORAL REASONING

Many medical educators have tried for a long time to identify measurable — or they'd even settle for describable — attributes of medical students that might possibly correlate with their later performance as physicians. If the correlation were high, then perhaps such a quantifiable attribute could serve as a predictor of the sort of person we "would all like to see" as physicians. An immense number of characteristics have been studied, but the results of such a quest have generally disappointed all who tried it, and also all who waited breathlessly for the result. Of course, there are large methodological problems, chief among them the difficulty in agreeing on what, or who is a good physician and how we can identify her or him.

An interesting article will shortly appear (JOURNAL OF EVALUATION AND THE HEALTH PROFESSIONS) that has looked at a different characteristic and, *mirabile dictu*, has found a reasonably solid correlation. The investigators, led by Dr. Joseph Sheehan, studied *moral reasoning*, using a paper and pencil test. The "test" presents six moral dilemmas and asks for responses to questions that probe the test-taker's decisions about which considerations are most important in resolving the issue, and the reasons for the decision. The final scoring is related to a widely used paradigm in ethics that

"ranks" types of ethical behavior in stages from low (based on punishments and obedience) to medium (based on conventional acceptance of societal or in-group rules), to high (based on universally valid ethical principles). At succeeding higher levels there is a "greater appreciation of the welfare of others and a greater desire to resolve moral dilemmas in a fair and equitable manner."

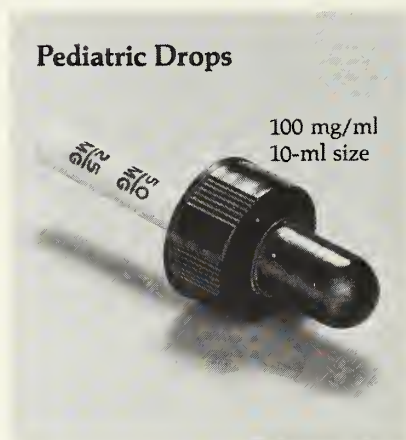
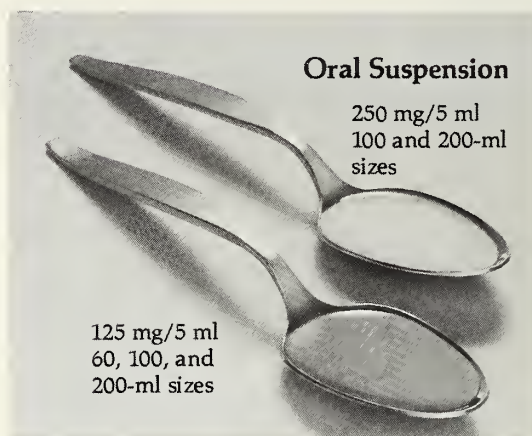
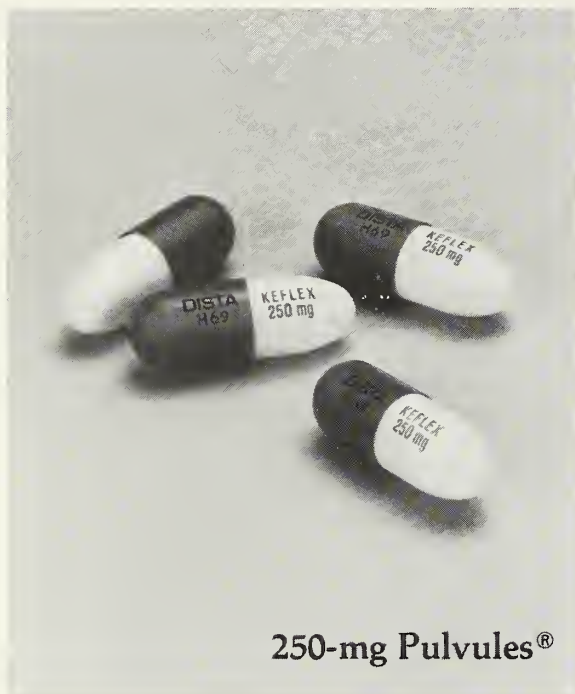
The test group consisted of 244 pediatric residents in 7 settings affiliated with university training programs. The determination of "good physician" was derived from scores derived in a standardized fashion from multiple faculty mentors. The inter-rater consistency was remarkably good (a correlation of 0.86). The overall correlation between moral reasoning score and physician performance was 0.57, which may not seem impressive, although it is, considering what poor correlations have usually been obtained in earlier work on this topic. Perhaps more important are the findings that when test scores and physician ratings are divided into high, medium and low groups, there was but one of 70 physicians with a high moral reasoning score who was rated low as a practicing physician, while only 6 among 60 of the moral reasoning low scorers gained a high rating from their clinical teachers.

The authors properly warn that pediatrics residents might not represent all practicing physicians (although I see no good reason to expect any particular bias in such a sample). They also warn that scores on a pencil and paper test of moral reasoning may say little or nothing about the moral *behavior* of the practitioner. Nevertheless, their results are stimulating. One can speculate about how it could be that the higher-level moral reasoner (note that is not identical to the "more morally behaving person") might become a superior physician. Go right ahead, speculate. But, it matters little whether the connection between the correlated variables makes any apparent sense as a cause-and-effect relationship; after all, if the transverse diameter of the thickest part of the ear lobule were found to be the best predictor of who'd be a good doctor, I'd use it eagerly, no matter how puzzled I'd feel about why it were so.

Wouldn't it be fun and possibly fruitful to extend this research to a study of established practitioners?

Dr. Caplan is Associate Dean for Continuing Medical Education at The University of Iowa College of Medicine.

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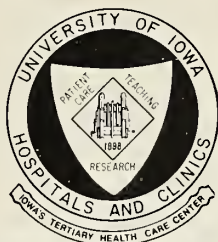
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DRUG THERAPY REVIEW



UNIVERSITY OF IOWA HOSPITALS AND CLINICS

REYNOLD SPECTOR, M.D., Editor

Editor's Note — In view of the cost, complications, and unproven benefit of total parenteral nutrition in many clinical situations, the physician ordering this treatment for adult patients should be clear about the indications for its use. Dr. Adel Al-Jurf of the Department of Surgery discusses the indications for total parenteral nutrition in the following article.

PARENTERAL NUTRITION: DEFINITION & INDICATIONS

The initial dramatic success of total parenteral nutrition (TPN) was followed by a period of enthusiastic application and subsequent over-extension. Recommendations for the use of TPN were often based on anecdotal experiences and thus created questioning as to the appropriateness and effectiveness of the technique in various clinical settings.

A basic objective of TPN, in most instances, is the preservation of the lean body mass during times when oral intake is not possible, is inadequate, or not recommendable. Superior goals such as decreasing mortality and morbid-

ity, hospital stay, or the convalescent period are desirable but either not established or constantly achievable.

The term "total parenteral nutrition" is currently used to describe the technique of supplying the total nutritional needs through a central vein as originally introduced and described by Dudrick. Since the introduction of many ancillary techniques and methods of parenteral nutrition, the term "standard" total parenteral nutrition came into use to refer to the original technique. The caloric needs in the standard technique are supplied essentially in the form of hypertonic dextrose and the proteinous needs in the form of crystalline amino acids. The solution must be delivered via a central venous catheter because of the high osmolality of the solution (over 6 times serum osmolality). The infusion is run basically at a constant rate. Lipids in this technique are supplied intermittently to prevent fatty acid deficiency but not as a major caloric source.

Modifications and ancillary techniques were introduced to avoid *certain* hazards or difficulties inherent in the standard technique or to meet specific needs in a subspecialized clinical setting. Those techniques include (1) peripheral nutrition with fat; (2) protein-sparing peripheral amino acids; and (3) cyclic hyperalimentation. The ancillary techniques, though highly popularized, fail to find profitable applications in most instances when compared to the standard technique. Detailed descriptions of those techniques and solutions, and the specific clinical settings that favor their selection are beyond the scope of this discussion.

The indications for parenteral nutrition can be classified into conditions where definite benefit is established, as a primary or supportive therapy; possible benefit is suggested, as a primary or supportive therapy; and experimental and subspecialized applications which are still under investigation.

(A) INDICATIONS WHERE DEFINITE BENEFIT APPEARS WELL ESTABLISHED

(1) *Gastrointestinal fistulae*: It is believed that the rate of spontaneous closure of fistulae has improved since the introduction and use of parenteral nutrition. The improvement in mortality, however, may reflect improved knowledge in patient care and management.

(2) *Short bowel syndrome and malabsorption*:

This information for Iowa physicians is furnished and sponsored by the University of Iowa Hospitals and Clinics.

DRUG THERAPY REVIEW

(Continued from page 25)

Parenteral nutrition is mandatory in people with short bowel syndrome, as absorption from the gastrointestinal tract is inadequate. Indefinite parenteral nutrition in some patients may prove necessary, but in many, hypertrophy of the remaining intestine may develop with time. Similarly, patients with malabsorption may require parenteral nutritional supplementation. These conditions represent the principal indications for home "hyperalimentation."

(3) *Acute renal failure*: In oliguric acute (reversible intrinsic) renal failure, parenteral nutrition (with hypertonic dextrose and L-essential amino acids) has been shown to produce many benefits: a decrease in mortality, earlier recovery of renal function, slower rise in BUN and protection against protein depletion. The frequency of dialysis and rate of recovery of renal function were not changed. The amount of L-essential amino acids sufficient to prevent protein depletion in this instance is that equivalent to 26 gm protein/24 hours.

(4) *Burns and trauma*: Basic energy expenditures and nitrogen losses may reach maximum levels in burns and trauma. The frequency of catheter sepsis in burns and the frequent need for more calories than can be tolerated by the parenteral route makes oral or tube feedings preferable whenever feasible.

(5) *Enteritis secondary to radiation or chemotherapy*: Supportive parenteral nutrition during periods of intestinal malfunction secondary to injury from radiation or chemotherapy appears useful. The use of parenteral nutrition as a therapeutic adjunct to radiation and chemotherapy is still under study and will be included in "Experimental Indications."

(B) INDICATIONS WHERE POSSIBLE BENEFIT IS SUGGESTED BUT NOT ESTABLISHED

(1) *Inflammatory bowel disease*: As a primary therapeutic measure, parenteral nutrition may produce prolonged remission of an acute attack and relieve acute obstruction in regional enteritis of the small bowel. Experiences are mostly anecdotal. In Crohn's colitis, and ulcerative colitis, parenteral nutrition is of supportive nutritional value only.

(2) *Anorexia nervosa*: Reversal or prevention of cachexia may facilitate psychiatric therapy and reversal of the anorexia.

(3) *Pancreatitis*: Parenteral nutrition is mainly of supportive value, without effect on the disease process. Prolonged symptomatic pancreatitis should stimulate investigating the possibility of the coexistence of a surgically correctable underlying etiology or complications that prevent resolution.

(4) *Prolonged ileus or stomal dysfunction*: It is often hard to predict the time of resolution of these conditions. Elderly people tolerate starvation poorly and require support earlier.

(5) *Peritonitis*: Prolonged intestinal dysfunction may accompany peritonitis and require parenteral nutritional support.

(6) *Cardiac surgery, cardiac cachexia, prolonged respiratory failure, and so forth*: Nutritional support in those diseases may become necessary over prolonged periods. The value of the routine application of TPN is not documented.

(7) Prolonged illness that could produce malnutrition, for example, stroke, coma, decubitus ulcers, and so forth, may indicate parenteral nutrition. Generally, most of those patients can be fed by tube feedings.

(8) *Preoperative preparation in major surgery*: Patients subjected to major surgery, who have lost 10-25% of previous body weight, developed less complications when parenteral nutrition was instituted preoperatively and carried on postoperatively. The routine use with major surgery is not justified.

(9) *Major protein depletion*: The ability of parenteral nutrition to replete wasted somatic protein stores over short periods of time is seriously questioned. Parenteral nutrition for such purposes appears impractical and not commendable.

(C) EXPERIMENTAL INDICATIONS

(1) *Cancer therapy*: Cachexia and anergy are often noted in many cancer patients, making them poor candidates for surgery, chemotherapy, or radiation therapy. Improvement of the nutritional status and immune response are feasible with parenteral nutrition but may not assure a better response to the therapy. Expectations for improved survival will be dependent on the effectiveness of available antineoplastic therapies. The routine use of parenteral nutrition in conjunction with some antineo-

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DRUG THERAPY REVIEW

(Continued from page 26)

plastic therapies should await the results of ongoing prospective studies.

(2) *Hepatic failure*: Branched chain amino acids were shown to decrease protein catabolism and improve encephalopathy. Those amino acids are not available yet for general use.

(3) *Renal failure*: The use of essential amino acids (Nephramine) was discussed earlier. Reduction of BUN by the use of alpha-keto acids and their possibly higher effectiveness in protein sparing needs further study.

The standard technique of total parenteral nutrition, despite its benefits, continues to be cumbered by certain limitations, drawbacks, and potential hazards. The need for a central venous access for the delivery of the hypertonic solution exposes the often seriously ill and depleted patient to mechanical complications during the catheter insertion and to sepsis or venous thrombosis during the course of TPN. (Catheter-related sepsis in our hospital was reduced to less than 2% with the institution of a specialized TPN nursing team.) Serious metabolic complications, despite appropriate expertise and knowledge, still occur and may prove fatal. The expense of the solution and the high wages of trained and specialized personnel make the cost-effectiveness an important point to consider. All these reservations assume added significance in view of the lack of unequivocal evidence for the effectiveness of TPN in reducing mortality, hospital stay, or the convalescence period in many of the accepted recommendations for TPN.

Pressing needs and anticipated benefits commonly outweigh the drawbacks or hazards; and the fear of potential complications should not discourage its use when appropriate indications exist.

Short periods of semistarvation in young and well-nourished patients may be tolerated without significant adverse effects. Such periods, however, are occasionally hard to predict and delaying parenteral nutrition may result in irreparable harm, if unexpected com-

plications arise. The age of the patient is of utmost importance; and older patients may not withstand prolonged semistarvation without showing ill effects. The higher the degree of recent weight loss, the stronger would be the indication for early parenteral nutrition. It is important to realize that preventing the development of nutritional deficits is possible with parenteral nutrition for any length of time, but repleting preexisting deficits is often hard or impossible. The basal energy expenditure, degree of catabolism, and extent of injury dictate the caloric needs. Hormonal response to stress and injury radically alters the metabolic milieu and produces abnormal substrate utilization.

The gastrointestinal tract should be utilized whenever possible by oral or tube feedings. The economical utilization of nutrients appears superior when the oral route is used. It is associated with less complications, greater caloric load tolerance, and, most certainly, it is less costly.

Nutritional services were established in many hospitals to ensure appropriate application of the available techniques as well as safe and professional care. At The University of Iowa Hospitals, consultation for nutritional support and catheter insertion in adult patients is provided through the Department of Surgery. Nutritional assessment and catheter care are also provided by a specialized nursing team of the same department. — ADEL AL-JURF, M.D., Assistant Professor of Surgery

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STATE DEPARTMENT/ PUBLIC HEALTH

ADVANCED EMERGENCY MEDICAL CARE

The State of Iowa continues to progress in the establishment and development of advanced emergency medical care. Eighteen months have passed since the rules implementing Chapter 147A of the Code of Iowa (Advanced Emergency Medical Care) became effective on July 5, 1979.

As of December 1, 1980, there are 15 service programs "authorized" to provide emergency care at the advanced life support level. The name, location and level of authorization of these services are shown on the accompanying map. Of these services, 3 function at the Advanced EMT-I level, 10 function at the Advanced EMT-II level, and 2 at the Paramedic level.

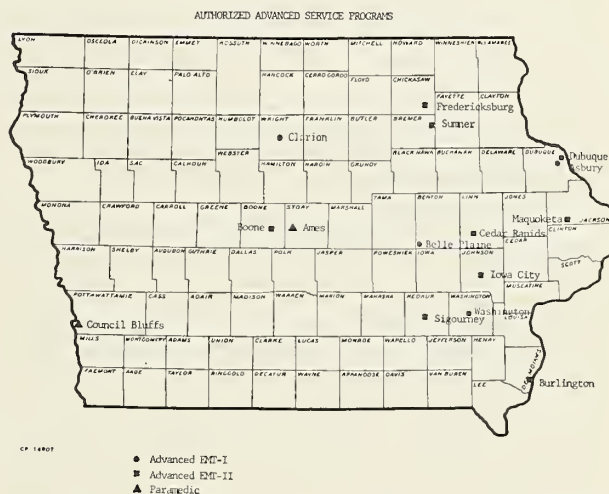
In reference to advanced techniques, Advanced EMT-I's are limited to intravenous therapy and use of the esophageal obdurator airway in conjunction with their basic life support skills. The Advanced EMT-II's and Paramedics are able to perform all advanced techniques stipulated in the law and the rules (i.e., administration of drugs, endotracheal intubation, cardiac defibrillation, etc.).

The vital role played by the medical director of an advanced service program (must be an M.D. or D.O.) cannot be overstated. The suc-

cess of this program and the rapidity with which it grows is in direct proportion to the involvement and direction received from the physician.

In order for an ambulance or rescue squad to receive authorization at a particular advanced level they must have a sufficient number of trained personnel certified by the Iowa Board of Medical Examiners to provide that level of care 24 hours a day, 7 days a week. They must also have a medical director provide medical control, standing operating procedures and a sound communications system.

The role of the State Health Department is to review the advanced care applications for compliance with the law and the rules, and to perform on-site inspections to further confirm eligibility for authorization. The final step in the



Circles on Iowa map above indicate EMT-I level of authorized service; squares indicate EMT-II level; and triangles indicate Paramedic level.

approval process lies in the hands of the Advanced Emergency Medical Care Council, chaired by James D. German, D.O.

Four additional service programs, in the final stages of obtaining authorization, are expected to be operational by the end of the year. This will bring the total number of authorized service programs to 19, of which 6 will be authorized at the EMT-I level, 11 at the EMT-II level, and 2 at the Paramedic level.

(Continued on page 30)

AUTHORIZED ADVANCED SERVICE PROGRAMS

<i>Service Name</i>	<i>Date of Authorization</i>	<i>Level of Authorization</i>
Area Ambulance Service 701 Tenth Street, SE Cedar Rapids, Iowa 52403	6/26/80	EMT-II
Boane County Hospital Ambulance Service 1015 Union Street Boane, Iowa 50036	5/19/80	EMT-II
Burlington Fire Department City/County Ambulance Service Fifth & Valley Streets Burlington, Iowa 52601	8/19/80	EMT-II
Chickasaw Ambulance Service, Inc. Fredericksburg Unit 315 Railroad Street Fredericksburg, Iowa 50630	6/26/80	EMT-II
Chickasaw Ambulance Service, Inc. Sumner Unit 315 Railroad Street Fredericksburg, Iowa 50630	5/19/80	EMT-II
Emergency Care Division 209 Pearle Street Council Bluffs, Iowa 51501	8/4/80	EMT-P
Jackson County Ambulance Service 700 West Quarry Street Maquoketa, Iowa 52060	7/21/80	EMT-II
Jahnsen County Emergency Ambulance Service 719 South Capital Iowa City, Iowa 52240	5/19/80	EMT-II
Keokuk County Ambulance Service RR #3 Sigourney, Iowa 52591	6/26/80	EMT-II
Mary Greeley Memorial Hospital Mobile Intensive Care Unit 117 Eleventh Street Ames, Iowa 50010	11/30/79	EMT-P
Asbury Community Fire Department 4904 Asbury Road Dubuque, Iowa 52001	11/20/80	EMT-I
Clarian Police Ambulance-Rescue 121 First Avenue SW Clarian, Iowa 50525	11/20/80	EMT-I
Dubuque Ambulance Service Ninth & Central Avenue Dubuque, Iowa 52001	11/20/80	EMT-II
Belle Plaine Area Ambulance Service 1611 Seventh Avenue Belle Plaine, Iowa 52208	11/24/80	EMT-I
Washington County Ambulance 902 West Monroe Washington, Iowa 52353	11/24/80	EMT-II

QUESTIONS/ANSWERS

(Continued from page 9)

icare A and B and the Iowa Pharmacy Service Corporation claims, all on a common computer program. Generally, it is possible to use existing phone lines for polling purposes.

In addition, the physician agrees to keep on file a verification of the subscriber's signature and verification that services indicated on the claim were actually performed. This information, of course, currently appears on all paper claims.

Our Blue Shield Professional Relations rep-

resentatives are available to discuss the specific requirements with interested physicians.

What is the bottom line in terms of savings, efficiency and impact on the type of care delivered?

The bottom line is efficiency and better service. Error reduction, quicker processing and faster payments make the claims filing process simple and cost-effective. After implementation costs, we expect a significant savings for physicians in employee time. The actual savings will depend upon the kind of equipment purchased, the number of claims filed, and the value the provider places on saved time, decreased postage costs, and clerical work for returned claims.

November 1980 Morbidity Report

Disease	Nov. 1980 Total	1980 to Date	1979 to Date	Most Nov. Cases Reported From These Counties
Amebiasis	0	9	78	
Brucellosis	0	6	7	
Chickenpox	867	8526	7985	Scattered
Cytomegalovirus	3	25	10	Johnson, Linn, Polk
Eaton's Agent infection	1	18	43	Humboldt
Encephalitis, virol	2	35	71	Pottowottomie
Erythema infectiosum	15	420	1081	Mitchell, Tomo
Gastroenteritis (GIV)	1812	17551	18111	Scattered
Giardiasis	5	38	44	Scott, Boone, Clinton
Hepatitis, A	22	180	181	Scott, Polk, Pottowottomie
Hepatitis, B	5	92	89	Polk, Woodbury, Pottowottomie
type unspecified	8	73	65	Pottowottomie
Herpes Simplex	11	107	77	Johnson, Linn Polk
Herpes Zoster	2	3	2	Johnson, Polk
Histoplasmosis	1	26	2	Scott
Infectious mononucleosis	53	342	471	Linn, Scott, Polo Alto
Influenza, lab confirmed	0	110	34	
Influenza-like illness (URI)	4143	59363	51163	Johnson, Linn, Polo Alto

Disease	Nov. 1980 Total	1980 to Date	1979 to Date	Most Nov. Cases Reported From These Counties
Meningitis				
aseptic	3	68	53	Lee, Polk, Wopello
bacterial	4	115	108	Polk, Scott, Butler
meningococcal	2	13	14	Buchanon, Story
Mumps	4	55	240	Block Hawk, Polk Jackson
Pertussis	0	2	3	
Robies in animals	52	468	181	Keokuk, Webster
Rheumatic fever	0	0	10	
Rubella				
(German measles)	0	9	53	
Rubeola (measles)	0	0	16	
Salmonella	22	178	176	Polk
Shigellosis	0	52	75	
Tuberculosis				
total ill	10	87	64	Linn, Polk Pottowottomie
bact. pos.	6	63	56	Linn
Venereal diseases:				
Gonorrhea	364	4690	5452	Polk, Linn, Block Hawk
Syphilis	8	31	30	Polk

Laboratory Virus Diagnosis Without Specified Clinical Syndrome: Guillain Barre Synd. — 1, Floyd; Legionnaire's — 1, Linn, 1, Webster, 1, Woodbury; Scarlet Fever — 2, Bremer, 1, Dubuque, 2, Linn, 9, Polk, 1, Pottowottomie, 1, Scott, 2, Winneshiek; Echovirus — 1, Hordine, 1, Jackson, 1, Johnson, 1, Kossuth, 2, Linn, 1, Polk, 1, Scott; Coxsackie — 1, Dubuque, 1, Johnson, 1, Polk, 1, Scott, 1, Winneshiek; Compyllobacter — 3, Dubuque, 1, Linn, 1, Marshall, 1, Polk; Toxic Shock Synd. — 1, Block Hawk, 2, Polk.

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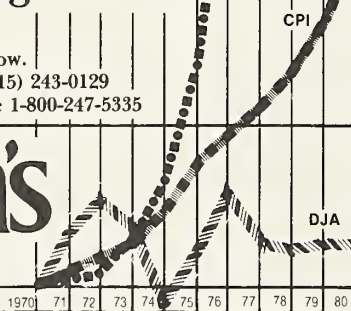
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Dr. Albert M. Dolan, Waterloo, has been elected to the board of directors of St. Francis Hospital. . . . Dr. Roger Westerlund and Dr. James McKlveen, Ames physicians, have been appointed recently to the American Board of Anesthesiology. . . . Dr. Donald E. Wolters, Estherville, will head a local campaign for Creighton University's Challenge for Century II development program. The program is a 5-year campaign to attract \$73.5 million to support Creighton University and the Creighton Omaha Regional HealthCare Corporation. . . . Dr. Robert G. Frazier, executive director, American Academy of Pediatrics, recently received the 1980 Clifford G. Grulee Award for outstanding and dedicated service to the AAP. From 1954 to 1958, Dr. Frazier was a faculty member in the Department of Pediatrics at the U. of I. College of Medicine.

Dr. Joseph E. Rose was honored recently for 50 years of medical service in Grundy Center. Dr. Rose received the M.D. degree at the U. of I. College of Medicine and interned at Marine Hospital in New Orleans, La. He began his medical practice in Grundy Center in 1931 and was the first county medical examiner. He is past president of the Grundy Center Board of Education, the Grundy Center Community and Rotary Clubs and past commander of the Grundy Center American Legion Post. Dr. Rose plans to continue his practice. . . . Dr. John L. Garred, Whiting, received a plaque recently noting his 25 years on the Whiting Community School Board. Dr. Garred decided not to run for re-election. . . . 255 persons competed in the first annual Medics ½ Marathon sponsored by the Woodbury Medical Society to promote physical fitness. . . . New officers of the Iowa Dermatological Society are — Dr.

(Please turn to page 34)



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Roger Ceilley, Des Moines, president; Dr. Winston B. Ditto, Burlington, vice president; and Dr. Tom Ray, Iowa City, secretary-treasurer. . . . Dr. Donovan F. Ward, Dubuque, was awarded the 1980 Alumnus of Distinction Award by the University of Dubuque at its homecoming festivities. Dr. Ward was also guest speaker at a recent meeting of the High 12 Club of Dubuque. His topic, "Medical Progress Yesterday and Today." . . . Dr. Leo Milleman, Ames, was a guest speaker at meeting of Iowa Academy of Family Physicians in Okoboji. Dr. Milleman spoke on "Cancer of the Prostate and Special Urological Problems as Related to the Family Practitioner."

Dr. Ronald D. Eckoff, chief, Community Health Division, Iowa State Department of Health, spoke on the history of boards of health at a recent workshop on the integration of health-related boards. Individuals from a 14-county area attended the day-long workshop conducted by the Iowa State University

Extension Service in Hampton. . . . Dr. Eugene Smith was inducted recently into the Hall of Fame at East High School in Waterloo. Dr. Smith has served as Black Hawk County medical examiner and assistant medical examiner for many years. He was county and city health officer for 17 years and worked to get fluoride into the Waterloo water system. During World War II Dr. Smith was a bomber squadron surgeon in the Pacific Theater and received the Air Medal. . . . Dr. Paul D. Anneberg has retired after 42 years as a Carroll physician. Dr. Anneberg is a past president of the medical staff at St. Anthony Regional Hospital; past president of the Carroll County Medical Society; and past president of the Iowa Urological Society. He plans to remain in Carroll. . . . Dr. Douglas L. Stanford has joined Drs. W. L. Telfer, L. A. Reeves and L. T. Betts in Waterloo. A native of Sutherland, Dr. Stanford received the M.D. degree at the U. of I. College of Medicine. . . . Dr. Kennedy Fawcett, Ames, was a guest speaker at the 10th Anniversary of the Kidney Foundation in Iowa City. Dr. Fawcett's topic "End Stage Renal Disease and the Juvenile Diabetic."

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Drs. Dale M. Grunewald and L. W. Matthews, Des Moines physicians, have been named fellows of the American Academy of Family physicians. . . . Dr. Charles Huss, Perry, is wintering at the South Pole. Dr. Huss was selected as team physician for 16 men and one woman who will spend the winter engaged in research at the American Amundsen-Scott South Pole Station. . . . Two Waterloo physicians Dr. James E. Crouse and Dr. Elias C. Jacobo, have been named fellows of the International College of Surgeons. . . . Dr. John R. Schiebe, Bloomfield, was elected president of the Iowa Chapter, American College of Surgeons at the body's recent annual meeting. . . . Dr. Mervin McClenahan, Dubuque, and Dr. Samuel W. Williams, Maquoketa, recently were named fellows of the American Academy of Family Physicians. . . . Dr. Steven J. Humphrey began family practice in Perry in November. Dr. Humphrey received the M.D. degree at U. of I. College of Medicine and served his family practice residency at Broadlawns Medical Center in Des Moines. . . . Dr. David Siroospour, Keokuk, and Dr. Michael F. E. Jones recently were named fellows of the

Aetna has returned over \$1 million in dividends to Iowa physicians.

Since the inception of the Iowa Medical Society Liability Insurance Program three years ago, Aetna has returned over \$1 million to Iowa physicians.

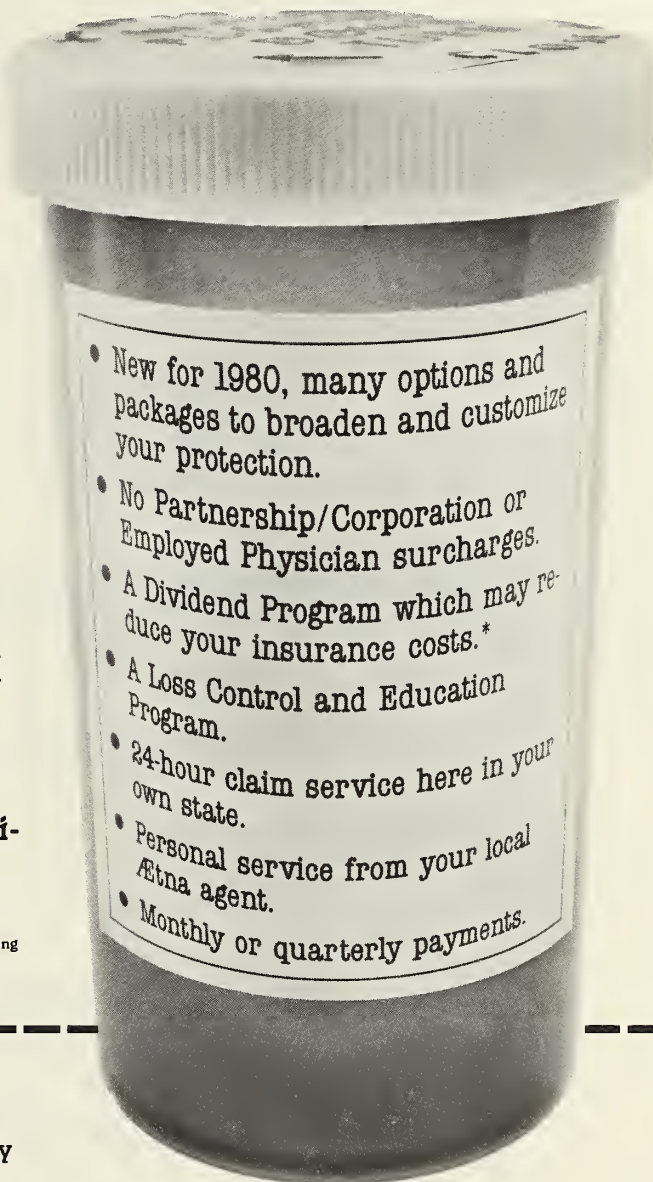
This year, physicians participating in the program will share in a half million dollar dividend.

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American College of Surgeons. . . . **Dr. Tom Smith**, Ames, was a program participant at annual meeting of American Academy of Otolaryngology.

Dr. Marvin R. Moles, Newton, is new president of the Iowa Academy of Family Physicians. Dr. Moles received the M.D. degree at the U. of I. College of Medicine and interned at Anker Hospital in St. Paul, Minnesota. He began his medical practice in Newton in 1956. . . . **Drs. Abdul Chughtai** and **Manmohan Kwatra**, Des Moines physicians, began a part time practice in Perry in December. Both doctors will continue their medical practice in Des Moines. . . . **Dr. John Collins**, Davenport, recently received the National Commander's Citation from Scott County Chapter 2 of the Disabled American Veterans. Dr. Collins was cited for his work in helping disabled veterans obtain compensation awards for service related injuries. . . . **Dr. L. C. Hickerson**, Brooklyn, retired from medical practice in December. Dr. Hickerson received the M.D. degree at U. of I. College of Medicine and interned at Duluth, Minnesota. He located in Brooklyn in 1940.

DEATHS

Dr. John W. Billingsley, 91, Newton physician since 1919 and Iowa state senator from 1935 until 1939, died November 9 at Skiff Memorial Hospital. Dr. Billingsley received the medical degree at Western Reserve University in Cleveland, Ohio; and took postgraduate training in Washington, D. C. He was a past president of the Iowa Medical Society; a life member of the IMS; and was the 1963 recipient of the Iowa Medical Society Merit Award.

Dr. Wilbur C. Thatcher, 72, Hackensack, Minnesota, longtime Fort Dodge physician, died October 13 at a Rochester, Minnesota hospital. Dr. Thatcher received the M.D. degree at U. of I. College of Medicine. He began his medical practice in Fort Dodge in 1937, retiring in 1971.

Dr. Robert W. Asthalter, 67, Muscatine, died November 18 at his home. Dr. Asthalter received the M.D. degree from U. of I. College of Medicine. He began his medical practice in Muscatine in 1945. A World War II veteran, Dr. Asthalter was a past president of the Muscatine County Medical Society.

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As part of Blue Cross and Blue Shield of Iowa's commitment to cost containment, we have included medical necessity criteria in subscriber contracts, eliminated the sale of diagnostic admission riders to our contracts, expanded diagnostic, x-ray and laboratory (DXL) benefits to 800,000 Iowans, and worked with the Foundation in developing a list of outpatient surgical procedures.

WE SHARE YOUR CONCERN FOR QUALITY CARE

Your support of cost containment measures such as utilization review will:

- Place the decisions of medical necessity into the hands of physicians, through the peer review mechanisms of local hospitals and the IFMC.
- Help reduce costs by eliminating unnecessary hospital stays and monitoring length of stay.
- Show your support of private sector initiatives in controlling health care costs.

Reducing expenses associated with high utilization is a responsibility that must be shared by the health care community as a whole.

We encourage your support of these programs which strive to make quality health care attainable and affordable.



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Blue Shield**
of Iowa

IOWA MEDICAL ASSISTANTS

SEE THE ROSES

A rose is a rose, is a rose. What a beautiful piece of art. Is there anything more beautiful than a single rose? What do you see when you look at a rose? The petals? The greenery surrounding the color? The long stems which make it appear very stately? Or are the thorns your first encounter when you try to pick up a rose? Let's tear a rose apart and see how it compares to our life.

First of all, there are many petals on each and every rose. Our jobs consist of friendliness, punctuality, filing, typing, preparing and instructing patients in the examining rooms, answering the phone, making appointments, filing insurance claims, collecting charges, etc. The rose petals can represent empathy, confidentiality, honesty, and other attributes. Of course, the more petals, the more beauty. So in our job, the more positive attributes, the more beautiful your job can be.

The continuing education, the willingness to learn the more difficult tasks, the desire to share the heavy load and volunteering to walk that extra mile when needed, can be compared to the additional beauty brought to the rose by the green leaves.

Of course, the rose is not complete without the thorns. The ups and downs of everyday living, the unpleasant patient or co-worker, the late night, all are thorns in the side. Since thorns are so visible in the beautiful rose, we can be certain our life will be more beautiful if we accept the thorns as they shine through our day's work.

Again, what is more beautiful than a single rose, adorned with its green leaves, long stem and thorns?

Material for this page is compiled by Frances M. Hansen, CMA-A, of Sioux City.

ELECTION RESULTS

The 1980 House of Delegates of the American Association of Medical Assistants elected the following officers: President: Dot Sellars, CMA-A, Virginia; Vice President: Betty Mays, CMA-A, Arizona; President-elect: Mabel Ann Veech, CMA-A, Kentucky; Secretary-Treasurer: Ivy Reade, CMA-AC, New York; Speaker of the House: Rita Paris, RT, LVN, CMA-AC, Texas; Vice-Speaker of the House: Luella Mitchell, CMA, Illinois; Trustees: Maxine Coody, Louisiana; Mary Haugen, CMA-AC, Indiana; Maurine Hensley, CMA-AC, Texas; and Mary Klinge, RRA, CMA-A, Kansas. *Congratulations to our leaders.*

BRING A GUEST

Any organization needs members. AAMA is no different. With summer activities behind us, and the winter doldrums at hand, it is a good time of the year to encourage your fellow workers to join the AAMA. Take a prospective member along to your monthly meeting, and prove to them that your educational program is stimulating. Active members share their organization. The attached poem says it all:

"SOMETHING TO THINK ABOUT!"

*Are you an active member
The kind that would be missed?
Or are you just contented
That your name be on the list?*

*Do you attend the meetings
And mingle with the flock?
Or do you stay at home
And criticize and knock?*

*Do you take an active part
To help the work along
Or are you satisfied to be
The kind that just belong?*

*Do you go to visit
A member who is sick
Or leave the work to just a few
And talk about the "clique?"*

*Think this over, member
You know right from wrong,
Are you an active member
Or do you "just belong?"*

Author unknown

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OFFICE SPACE AVAILABLE — 834 sq. ft. of beautiful office space in the Des Moines Medical Center, south of Mercy Hospital. Walnut paneling, completely carpeted, spacious front office and waiting room, two exam rooms, two bathrooms and fabulous executive office with view of the Capitol and Botanical Center. All utilities, maintenance and office

cleaning included. \$12.00/sq.ft./annum. Contact Steve R. Eckstat, D.O., P.C., 1044 4th Street, Des Moines, Iowa 50314. Phone 515/282-8131.

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FAMILY PHYSICIAN — needed to join an established rural family practice near Waterloo, Iowa. Prefer A.B.F.P. Full hospital privileges in Waterloo hospitals. Good schools, golf course, tennis courts. Write or call W. H. Verduyn, M.D., Rural Family Practice Clinic, PC, 514 Main Street, Reinbeck, Iowa 50669. 319/345-6461.

FAMILY PRACTITIONERS WANTED — 49-year-old board certified family practitioner in Cherokee, Iowa, the past ten years, is starting a new group practice. Modern hospital available. New clinic building on the drawing board. More information available from Gene E. Michel, M.D., 415 North 9th Street, Cherokee, Iowa 51012. ALL REPLIES CONFIDENTIAL.

PHYSICIAN — Family Practice — \$60,000/Yr. — 60 Hours/Week. Practice in a modern medical clinic; completion of AMA recognized internship; licensability and highly acceptable references required. Contact Joyce Reitinger, Mercy Health Center, St. Mary's Unit, 1111 Third Street, S.W., Dyersville, Iowa 50240.

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In The Public Interest

About Claim Review Panels



SUPPOSE FOR a minute, be you physician or patient, that you're party to a situation where the delivery of medical care has gone astray in some way. The circumstances have led to the filing of a liability action which is highly complex. A thoughtful, objective and complete evaluation of the matter has become quite necessary.

How do you proceed to a fair and equitable dispensation of the matter?

Despite conscientious and skilled efforts in the daily provision of medical care, these instances do occur. Their resolution requires capable legal direction, a full evaluation of precisely what happened, and able interpretation of the actions (or lack thereof) taken. It is a vital and arduous task.

The aforementioned fair and equitable conclusion is perhaps achievable in several ways. Generally, the responsibility for adjudication of a medical liability claim resides with that insurance company covering the physician — and additionally with companies of any other defendants party to the case. The selection of legal counsel is a usual determination of the insurance company.

Into the adjudicatory milieu, in 1977, came the Iowa Medical Society. This all occurred with the birth of the IMS/Aetna Liability Insurance Program. Said program has grown steadily in its several years and now involves approximately 1,200 IMS member physicians.

Back however to our initial question about the handling of a complex or difficult instance where liability may or may not have been present. Under the IMS/Aetna program, an instrument called the claim review panel comes into the picture. The CRP brings valuable and objective medical expertise to bear on any potential liability situation. It is the goal of the review panel program to help assure that a proper decision is made on the handling of a

case, i.e. (a) there was liability and some type of settlement should be sought, or (b) there was no liability and a strong defense should be pursued.

How does the claim review panel work?

A CRP is requested either by the Aetna or by the physician against whom the claim has been presented or by trial counsel. A CRP chairman is selected, as is a case manager. Then a panel of from 8 to 12 members is formed. All participants are physicians and come from medical specialties having some relation to the case. The case manager presents the panel with the medical facts; the panel discusses the circumstances both independently and with the physician involved; a vote is taken on the several possible alternatives and this is directed through proper legal channels to the defense counsel. A claim review panel usually consumes from 2 to 3 hours.

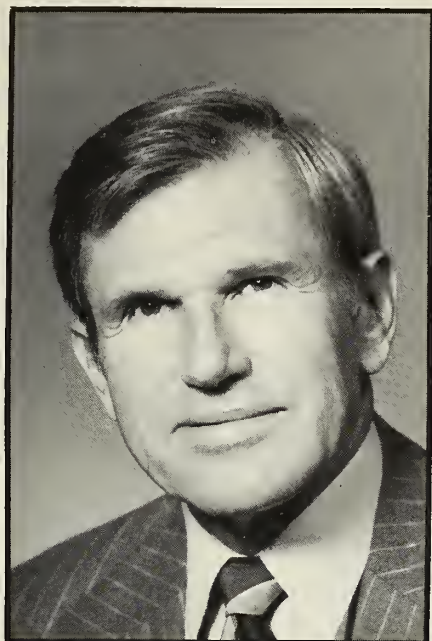
In addition to bringing medical expertise to bear on a particular situation, the CRP has a by-product value. The panel has demonstrated a unique ability to function as an educational experience for the participants. It has the effect of demonstrating to physician panelists that problems do occur and full appropriate attention must be paid at all times, first, to assure quality care, and, second, to avert any likelihood of liability.

The claim review panel is part of a broader risk management program instigated under the IMS/Aetna banner. This total effort is meant to keep medical practice in Iowa as free of malpractice as possible.

To date there's been full objectivity when IMS physicians have gathered to hold a claim review panel. The interests of the patient and the involved physician have been evaluated on equal terms. This relatively new exercise within the IMS operative framework is indeed important and *In the Public Interest*.

January 1981

Journal of the Iowa Medical Society



PRESIDENT'S PRIVILEGE

I needn't remind you that the use of hospital beds is an issue of substantial current importance. You are aware of the continuing discussion about the overuse/underuse of inpatient facilities.

My reason for mentioning this critical topic now is to call your attention to a new project which involves the medical profession and, more specifically, the Iowa Medical Society.

Preliminarily, let me say, as you may know, there are within Iowa several organizations that have collected and published utilization rates for acute care. A generally accepted conclusion has been that the use rates for Iowa hospitals are higher than regional and national averages. Also, the figures have shown rates within Iowa vary significantly from county to county.

Legitimate concerns have been raised as to the validity and representativeness of the figures used to criticize the Iowa picture. Some believe little effort has been made to identify various factors that impact on utilization. I refer here to population distribution, accessibility of facilities, availability of health care personnel, etc. These elements need to be analyzed and understood before we accept as inappropriate the level of hospitalization occurring in Iowa.

To this end, the Iowa Voluntary Cost Containment Committee (IVCCC), of which the

IMS is a joint founder and an active participant, is embarking on a study to obtain a data base from which we can learn more about Iowa hospital use. Out of this IVCCC study may come some recommendations to modify the overall direction of inpatient care by Iowans. Our plan is to review the findings and seek implementation of appropriate and feasible measures.

Along with the Iowa Hospital Association, the Blues and the Iowa Society of Osteopathic Physicians and Surgeons, the IMS is part of the IVCCC research team devised to guide the study. The Society's Board of Trustees recently authorized participation. A first phase is now in process to identify and retain a consultant to develop the methodology and undertake the data collection.

The study will run into 1982. A final report will then be available. We hope to find answers to some important questions about the use of Iowa hospital beds. The results should be useful to all of us.

William R. Bliss, M.D.

William R. Bliss, M.D.

THINGS YOU SHOULD KNOW

APPEAL DECLINED

The Eighth Circuit Court of Appeals has declined to hear appeals requested by plaintiffs and defendants in the case brought by the Health Equalization Committee of the Iowa Chiropractic Society. This action leaves in tact an earlier ruling exempting Blue Cross/Blue Shield from the antitrust claim. The case (which involves the IMS as a defendant) now reverts back to its original jurisdiction and will proceed.

MANAGEMENT WORKSHOP

On Wednesday, March 18, a Workshop on Management of Medical Offices/Clinics will be presented at IMS headquarters. The program will be given by a practice management expert from the American Medical Association. The session is primarily for personnel supervising medical office operations, but will benefit physicians who manage their practices. Physicians may earn 6 Category I CME hours. A \$30 fee will be charged. The limited enrollment (30) will be on a first come/first served basis.

HOSPITAL RATES

Room rates in Des Moines' six hospitals increased 16.6% in 1980, according to a survey reported in January by the Des Moines Tribune. The national 17.1% hike in hospital labor costs was cited by Iowa Hospital Association officials as a main reason for the continuing upward movement. The private room rate in Des Moines ranged in the survey report from \$126 to \$157.

MORE ON COSTS

Also reported in January were Blue Cross/Blue Shield figures showing hospitalization in Iowa cost an average of \$242.92 daily in 1980 -- up \$30.50 from 1979. The average total hospitalization in 1980 was \$1,393.21 -- compared with \$1,218.96 in 1979. Iowa charge increases were 15% in 1980.

HOSPITAL STAYS

Further, according to BC/BS, Iowa hospital admissions continued to run ahead of national figures. Iowa had 164 patients admitted per 1,000 persons in 1980, compared with 116 nationwide. These statistics apply to BC subscribers under 65. 948 days were spent in Iowa hospitals per 1,000 population compared to a national figure of 723.

MEDICAL STAFF MATTERS

A Medical Staff Leadership Seminar will be put on jointly by the IMS and AMA at Society headquarters on Wednesday, March 11. The all-day session is geared for chiefs of hospital medical staffs, but is available to any interested physician. Contact the IMS for more info.

BME CME

The Board of Medical Examiners is seeking IMS input on the revamping and further simplification of the BME continuing education reporting form. The second distribution of the report form to Iowa physicians is planned for early spring.

REGULATION MATTERS

The Board of Medical Examiners issued proposed rules in January covering the functions of physician's assistants in satellite clinics and also covering packaging, labeling and record-keeping of Rx drugs by dispensing physicians. Recent Board of Nursing proposed rules covering nursing functions received IMS comment at a January 28 hearing.

SYPHILIS SEROLOGY

As part of state budget curtailments, the University Hygienic Laboratory has discontinued syphilis serology testing for premarital and routine physical examinations. The UHL reports this action necessary so it can provide services that require more specialized test procedures. There are over 100 other labs in Iowa equipped to do the test.

This is a continuing medical education presentation. The content is drawn from a shared study conducted by the Iowa Foundation for Medical Care among 67 Iowa hospital medical staffs. The subject covered is the proper use of Rh Immune Globulin. You will find a special orange-colored one-page insert at the conclusion of this article. This insert contains an 8-question quiz. You are invited to complete this quiz, remove it from the JOURNAL and mail it with \$2 (to cover administrative costs) to the Iowa Foundation for Medical Care. The quiz will be evaluated and returned to you with appropriate comments. If you complete it satisfactorily (scoring criteria of 75% or better) you will be granted one credit hour in Category 1 for the Physician's Recognition Award of the American Medical Association. This educational project is a joint service of the Foundation, the University of Iowa College of Medicine and the Iowa Medical Society.

Proper Use of Rh Immune Globulin: Report of a Statewide Study

CHARLES DRISCOLL, M.D.,
RICHARD CAPLAN, M.D., and
HAROLD VANHOFWEGEN, M.D.

THE USE OF Rh immune globulin (RhIG) to prevent hemolytic disease in the newborn represents a modern medical triumph. The Rh factor was discovered in 1939. By 1964 fetal wastage due to Rh incompatibility was considered a

CME/SSR **No. 1 in a Series**

potentially preventable disease. In 1968, Rh immune globulin became available commercially; yet, by 1974, national use of the appropriate treatment was estimated from 78% to 91%.¹ This means approximately 10-20% of mothers at risk of Rh sensitization were not receiving the protection so readily available.

This disease is now almost entirely preventable. Both the effort and the cost are relatively

The authors are members of the Continuing Medical Education Committee of the Iowa Foundation for Medical Care. Other committee members who contributed are Robert Pfaff, M.D., and George West, M.D. The additional assistance of Clifford Goplerud, M.D., William Keettel, M.D., Stanley Greenwald, M.D., and Jennifer Cofer, M.A., is acknowledged.

insignificant. However, the right procedures must be performed at the right time.

The Continuing Medical Education Committee of the Iowa Foundation for Medical Care conducted a statewide study in 1978 to determine (a) if Rh tests are being conducted when appropriate, and (b) if RhIG is being given when indicated. The study had 67 participating hospitals. Records of 5,810 patients were involved. The patients were under the care of 485 different physicians. The numbers (hospitals and patients) are large and represent an unusually extensive survey of health care procedures with respect to hemolytic disease of the newborn. About half the hospitals in Iowa are included in this shared study program

CME/SSR

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coordinated by the professional standards review organization (PSRO). The hospitals represent a typical cross-section of the inpatient facilities in Iowa.

Each hospital was requested to survey 100 records of pregnancy-related care. This was to include induced or spontaneous abortions, ruptured ectopic pregnancies, and deliveries. Cases were accumulated in reverse time order starting June 30, 1978, and going back no further than July 1, 1977. This report will review the 5 criteria studied, summarize the findings and offer recommendations.

Criterion 1: A pregnant patient's Rh type should be determined and recorded in her chart. Forty of 67 (60%) hospitals had one or more deficiencies here. We were unable to determine fully whether the absence of information represented a failure to obtain the test, or if the test results were omitted from the chart.

Of the total patients, 94.7% had an Rh test performed appropriately. This is an improvement over the 78-91% figure reported in 1974. Still, the ideal of testing all women at risk has

not been achieved. Of 433 variations identified, 313 were called deficiencies after review by a staff committee in the participating hospital. These deficiencies were not investigated by looking into office or hospital laboratory records, so some portion of the deficiencies may stem from failure to get data onto the patient's hospital record.

On the other hand, one hospital had 70 charts containing no Rh test. This lack of documentation was justified in 52 instances by saying, "Oftentimes it is done in the doctor's office." But the physicians at that hospital agreed a change was needed. A new policy was established that henceforth all pregnant patients would be sent to the hospital laboratory prior to delivery to have Rh type determined and entered in the hospital record. It was recognized this new procedure would reduce duplication and costs.

The prevalence of Rh negative blood type is estimated at 15% in a generally Caucasian population as exemplified by Iowa. We thus estimate 872 patients in our total sample might have been Rh negative. Assuming a random distribution, 47 Rh negative mothers may have been among those 313 instances labeled "deficient." Romney *et al* stated only 6% of the pregnancies of Rh negative women become sensitized.³ Using this risk estimate, we theorized 3 women from our study population could have become sensitized by the Rh factor during the time of this study. If we extrapolate from our study sample of 5,810 to the average number of annual births in Iowa for 1977 and 1978 (44,729), we estimate perhaps 21 Iowa women in the year we studied did not have sensitization prevented by proper use of RhIG, simply because the fact of their being Rh negative, and thus at potential risk, had not come to light.

Considering the cost of intrauterine transfusion and the morbidity and mortality that could ensue from this oversight, we need continued effort to test and document the Rh status.

When we examine the kinds of patients missed in Rh factor testing, we find about a fourth involved spontaneous or therapeutic abortions. Another fourth of the deficiencies were not identified as to delivery or abortion-related. Grimes *et al*⁴ discussed the problem of under-utilization of RhIG after abortion. They

found 19% of the patients failed to receive RhIG after spontaneous abortion compared to only 1% in the induced abortion group. Grimes rightly states patients undergoing elective termination of pregnancy are often managed according to a protocol; patients having spontaneous abortions, however, are usually not managed in such a way, and the chances of failing to test for Rh status and to administer RhIG thereby increase. Developing a protocol to insure Rh testing in all cases of abortion, either spontaneous or induced, might have corrected over a fourth of our presently reported deficiencies.

Criterion 2: If Rh type of the mother is positive, no RhIG should be given (since there is no risk). Only one "deficiency" was reported: RhIG was given to a woman whose Rh type was not known or documented. Strictly speaking, this instance should not have been termed a deficiency under this criterion; the real error here was failure to meet Criterion 1.

Criterion 3: If a third-trimester delivery occurs in an Rh negative woman, an indirect Coombs titer test should be performed on the mother's blood and the Rh type of the baby should be determined. The reasons are: (a) if the baby is also Rh negative, there is no danger of sensitizing the mother and no RhIG needs to be given to the Rh negative mother; or (b) if the mother has unexpected antibodies, indicating that sensitization already exists, RhIG will not be warranted, but the baby will need to be followed carefully and an exchange transfusion will need to be considered.

In our series, 124 variations were found, but local committees identified only 53 as unjustified. This many instances of failure to perform proper workup may well have included instances of omission and commission; that is, not giving RhIG when warranted, or giving it when unnecessary or even contraindicated (Rh positive mother or previous active isoimmunization).

Criterion 4: If the mother is Rh negative and she is not isoimmunized (and in a third-trimester delivery, the baby is Rh positive), then RhIG should be administered within 72 hours of the delivery or procedure. This is the key action item in the entire study. Some authorities argue that failure to perform and document this step when indicated is tantamount to malpractice. In our sample there were 6 instances of "deficiencies." Of the 313 patients of unknown Rh status, we

cannot be certain how many additional women ought to have received RhIG; from epidemiologic data we estimate it might have been another 5, since there is a 10% probability that an Rh negative mother will deliver an Rh positive child.²

A comment is warranted about administering Rh immune globulin following a sterilization procedure. For the purposes of enumerating the deficiencies under this criterion, any patient who underwent sterilization at the time of delivery or abortion was not included as a deficiency even if RhIG was not administered to an Rh negative mother. This remains controversial. Scott,⁵ in 1975, concluded routine

For Category I Credit See Quiz Following

use of RhIG in such instances may not be justified on a cost/benefit basis. The principal argument for its use is the possibility that such a patient would again become pregnant, either because of failure of the sterilization or because of a successful attempt at sterilization reversal. Current data indicate the demand for sterilization reversal is increasing and estimates of the number of women who regret having had sterilization range from 0.6% to 6.9%.⁶

Criterion 5: Not more than one administration of RhIG should occur on any one admission. This criterion disclosed 6 instances of variation but only one of those was deemed a deficiency. Those variations that were justified seemed appropriate because the mixing of fetal and maternal blood was estimated to exceed 30 ml. If such mixing is suspected, it can be proven by the Kleihauer-Betke test, which distinguishes fetal (pink) from maternal (ghost) red cells after acid elution. In general, 300 micrograms of RhIG should be given for every 30 ml of fetal blood estimated to have entered the maternal circulation.⁷ Another exception to the only-one-vial rule would be the occurrence of a

transfusion accident in which an Rh negative woman was transfused with Rh positive blood. In that uncommon event, the number of vials to be administered can be estimated by the formula:

$$\text{number of 300 mcg vials} = \frac{\text{ml of packed cells given}}{15}$$

(if whole blood is used, the denominator becomes 30). When a fraction results, the "rounding" should occur upwards. (For example, if 100 ml of packed cells are transfused before the mistake is discovered, the number of vials of RhIG should be 7, i.e., $\frac{100}{15} = 6.7$). The RhIG is administered in divided doses up to 1500 mcg at one site.

CME/SSR

No. 1 in a Series

A final comment on the dose of RhIG relates to spontaneous and induced abortion. Recent studies have been conducted by Stewart *et al*⁸ regarding use of a smaller dose of RhIG following first-trimester pregnancy termination. They reported 1,027 subjects undergoing vacuum abortion at 12 or fewer weeks of gestation and used an RhIG dose of 50 micrograms. Their study demonstrated this lower dose to be 100% effective in preventing Rh isoimmunization as detected by serologic testing 6 months after the abortion. To use a reduced dose under such circumstances, and thus lower cost, is a new development that merits further investigation.

SUMMARY

Iowa physician use of RhIG seems to be proper. This Iowa use is at a level that exceeds national estimates made 5 years ago. For the following reasons total application of RhIG procedures is advocated: (a) universal availability of the necessary tests, (b) important implications of failure to perform appropriately,

(c) low cost (approximately \$32/vial), and (d) remarkable effectiveness of RhIG.

Specific deficiencies disclosed in this study included: (a) 5.3% of instances failed to have mother's Rh type performed/documented; (b) among the estimated 872 Rh negative women in our study population, 53 (6.1%) did not have an appropriately complete workup for isoimmunization titer and typing of the baby's blood; (c) in our study population there were 6 instances when RhIG should have been administered and was not, plus the possibility of another 5 among women whose Rh type was not recorded in the medical record. If these 11 instances are extrapolated to the total annual births in Iowa, we obtain a figure of 35 instances that probably should have received RhIG and did not. We do not think complacency is warranted.

Action is recommended to remedy both the knowledge and performance deficits that exist. For the knowledge gap each hospital should urge its staff physicians to be certain they understand the disease process of Rh sensitization and its prevention, not only in third-trimester deliveries, but also for spontaneous and elective abortions and instances of ruptured ectopic pregnancy. For the behavioral gap, each hospital should develop an administrative protocol to remind physicians and nurses to properly ascertain Rh status and administer RhIG when indicated. The protocol might be as little as a reminder posted at the desk of the delivery suite or the recovery room, or an Rh-procedure slip to be affixed to the chart-face of every patient having a pregnancy-related procedure. Another option might be to delegate to nursing service the responsibility to check each patient record and initiate proper action steps.

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PROPER USE OF Rh IMMUNE GLOBULIN

This learning experience is intended for all health professionals caring for pregnant women. When the learner completes this reading he/she will be able to: (a) explain why all pregnant women need to be tested for Rh type, (b) state the major reasons which may explain the continuing occurrence of Rh sensitization of the newborn, (c) correctly identify women who should be given Rh immune globulin and correctly state the dose to be given.

The following brief test gives you the opportunity to assess your knowledge of the subject discussed in the preceding summary report. The test will help you measure your retention of the material presented.

One hour of continuing medical education credit (AMA Category 1) is offered to those who read the article carefully and answer the questions. You are invited to answer the questions and submit them with the information requested. Simply (1) check the correct answers, (2) enter the information requested, (3) remove this page from the JOURNAL, (4) prepare a check for \$2 (to cover administrative costs) made payable to the University of Iowa, and (5) mail the quiz and check to the Iowa Foundation for Medical Care, Colony Park Suite 500, 3737 Woodland Avenue, West Des Moines, Iowa 50265. You will be provided a report on your quiz and a confirmation of the CME credit by return mail.

As an organization accredited for continuing medical education, The University of Iowa College of Medicine designates this continuing medical education activity as meeting the criteria for one credit hour in Category 1 for education materials for the Physician's Recognition Award of the American Medical Association provided it has been completed according to the instructions.

PLEASE ANSWER THE FOLLOWING QUESTIONS

1. A significant number of Rh negative mothers at risk for sensitization fail to receive Rh immune globulin prophylaxis. What is the national estimate of the magnitude of this error?
 - ☐ a. 1-5%
 - ☐ b. 5-10%
 - ☐ c. 10-20%
 - ☐ d. 20-30%
 2. The Kleihauer-Betke test can:
 - ☐ a. establish that mixing of fetal and maternal blood has occurred.
 - ☐ b. prove Rh sensitization has occurred.
 - ☐ c. estimate the amount of fetal blood loss before delivery.
 - ☐ d. determine the fetal blood Rh factor before delivery.
 3. Regarding the prevention of Rh isoimmunization in induced early first trimester abortions, recent studies have suggested that:
 - ☐ a. this procedure necessitates RhIG doses in the range of 300-600 micrograms.
 - ☐ b. as little as 50 micrograms of RhIG is 100% effective.
 - ☐ c. several times the standard dose of RhIG may be necessary.
 - ☐ d. there is a lack of effectiveness of RhIG doses less than 300 micrograms.
-

-
4. Rh immune globulin is contraindicated in all but one of the following case examples. Select the one example which does not represent a contraindication to the use of RhIG.
- ☐ a. an Rh positive mother delivering a term Rh negative fetus.
 - ☐ b. an Rh negative mother with prior active isoimmunization.
 - ☐ c. an Rh negative mother with miscarriage at 9 weeks gestation.
 - ☐ d. an Rh positive mother who is indirect Coombs positive after delivery.
5. Rh immune globulin should be administered by which of the following routes?
- ☐ a. intramuscularly
 - ☐ b. intravenously
 - ☐ c. subcutaneously
 - ☐ d. orally
6. Rh negative women undergoing elective termination of pregnancy very early in the first trimester:
- ☐ a. should always receive RhIG if not previously sensitized.
 - ☐ b. have inconsequential risk for Rh sensitization and do not need RhIG.
 - ☐ c. should have the Kleihauer-Betke test before any RhIG is given.
 - ☐ d. are less likely to appropriately receive RhIG than patients having had a spontaneous miscarriage.
7. Rh immune globulin should be administered if:
- ☐ a. the mother is Rh negative and the newborn is Rh negative.
 - ☐ b. the mother is Rh negative, indirect Coombs positive.
 - ☐ c. the mother is Rh negative and the father is Rh positive.
 - ☐ d. the mother is Rh negative and has a spontaneous miscarriage at 13 weeks gestation.
8. About one-fourth of the patients who are missed in Rh factor testing might best be identified if:
- ☐ a. the problem of the under-utilization of RhIG is communicated to the laboratory and blood banking service.
 - ☐ b. a nursing protocol is established to insure Rh testing in all cases of abortion, induced or spontaneous.
 - ☐ c. an educational letter on the subject of the under-utilization of RhIG is sent to all physician members of the medical staff.
 - ☐ d. Rh testing replaced the VDRL as a routine admitting laboratory test on all patients entering the hospital.
-

PLEASE DO THE FOLLOWING IN ORDER TO RECEIVE CREDIT:

1. Be sure your answers are indicated in the boxes provided.
2. Remove this page from the JOURNAL.
3. Make a check for \$2 payable to the University of Iowa to cover administrative costs.
4. Insert the information requested below.
5. Mail this page and check in an envelope to Iowa Foundation for Medical Care, Colony Park Suite 500, 3737 Woodland Avenue, West Des Moines, Iowa 50265.

NAME _____

ADDRESS _____

MAKE YOUR MARK AND BE COUNTED...

If you haven't already, now is the time to complete the 1981 Census of Physicians' Professional Activities.

Doing so will assure:

- that your official record is updated
- that you are accurately represented in the 28th Edition of the *American Medical Directory*
- that you continue to receive the educational and scientific materials relevant to your professional interests

Call or write if you have not received a census form

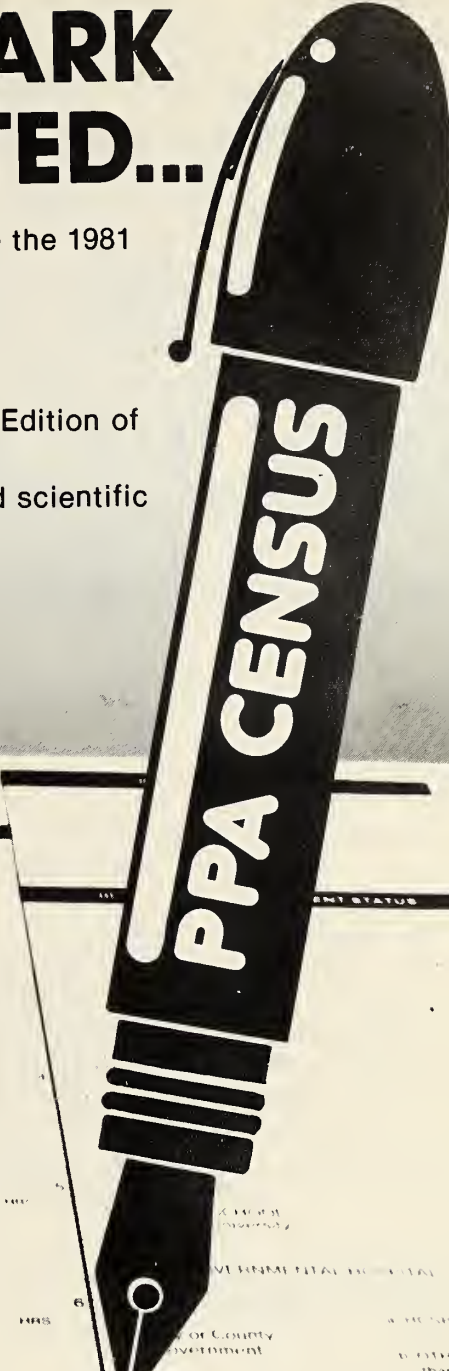
Division of Survey & Data Resources

American Medical Association

535 North Dearborn Street

Chicago, Illinois 60610

312-751-6435



1. PHYSICIAN'S PERSONAL DATA (please print)

2. How many hours per week do you spend on DIRECT CARE of Patients?

3. How many hours per week do you spend on ADMINISTRATIVE ACTIVITIES as a Salaried Staff Member or Executive of an Organization?

4. How many hours per week do you spend on MEDICAL TEACHING?

5. How many hours per week do you spend on MEDICAL RESEARCH?

6. How many hours per week do you spend on other medical activities (not listed above) involving DIRECT CARE OF PATIENTS?

7. How many hours per week do you spend on OTHER MEDICAL ACTIVITIES (not listed above) not involving care of patients?

About how many hours per week do you spend in ALL PROFESSIONAL ACTIVITIES? For Residents, this is the total of questions 1, 6 and 7. For all other physicians this is the total of questions 2 - 7.

8. If the TOTAL in question 8 above is 20 hours or less, please answer question 9.

9. Indicate Federal Agency

10. OTHER ORGANIZATION (all types of insurance carriers, companies, corporations, voluntary societies, associations, grant...

Total of Section I equivalent to total of Section II, and total of Section III, respectively.

you:

Retired ☐ **Semi-retired** ☐ **3** ☐ **Permanently Disabled** ☐ **temporarily not in practice** ☐ **not active for other reasons (please describe)** ☐

10

WE'VE HELPED IMS PHYSICIANS WITH INSURANCE NEEDS SINCE 1955



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As long-time insurance administrators and counselors for the Iowa Medical Society, it has been a privilege to furnish assistance to Iowa physicians on insurance and other financial matters.

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We welcome the opportunity to serve you as a member of the Iowa Medical Society. Requests for information by phone or mail will receive prompt attention.

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VOX DOCS

Please take a look below at this month's Vox Docs question. Give us your answer. Send it to IMS JOURNAL, 1001 Grand Avenue, West Des Moines, Iowa 50265. Last month's question and answer results are shown to the right with several of the comments printed below.

"First dollar coverage must be responsible for a great degree of the cost of health care. It will be difficult to take it away from those who have obtained it at employer's expense through contract bargaining." — *James F. Bishop, M.D., Davenport*

"Decelerating inflation will be the most helpful single item to make feasible our cost containment efforts. Also I suggest more critical scrutiny of hospital charges by third party payors." — *John S. Chapman, M.D., Dubuque*

"Keeping the government out of medicine will only work if we all become involved in keeping costs under control and keeping our house in order." — *David B. MacMillan, M.D., Waverly*

"When are the specialty groups going to realize that these new procedures don't have to be priced higher than any other procedure?" — *Dan M. Youngblade, M.D., Sioux City*

LAST MONTH'S QUESTION —

The AMA has announced a major 1981 program on cost effectiveness. Are you willing to share individually in this further and stepped-up non-governmental program to restrain the increase in medical care costs?

YES	88%
DON'T KNOW	12%

"The ability of the medical and associated professions to restrain the increasing costs of health care by deliberate selection will be the test of our professional credibility. The removal of marketplace forces by third party payment lays the burden squarely upon us." — *Norman W. Hoover, M.D., Mason City*

"I would focus primarily on increased efficiency of health care delivery systems with special incentives for outpatient treatments and decreased hospital stays supported by insurance carriers and government programs, along with decreased administrative overhead." — *Leo Milleman, M.D., Ames*

FEBRUARY QUESTION FOR IOWA PHYSICIANS

As we move to its second year as a requirement, would you say that making continuing education a condition for maintaining an Iowa medical license is a good thing?

- ☐ YES
☐ NO
☐ DON'T KNOW

Comment, please _____

Name _____

Address _____

(Please Complete & Send to IMS JOURNAL, 1001 Grand Avenue, West Des Moines, Iowa 50265)

An added complication... in the treatment of bacterial bronchitis*



Brief Summary Consult the package literature for prescribing information.

Indications and Usage: Ceclor* (cefaclor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms:

Lower respiratory infections, including pneumonia caused by *Streptococcus pneumoniae* (*Diplococcus pneumoniae*), *Haemophilus influenzae*, and *S. pyogenes* (group A beta-hemolytic streptococci).

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Ceclor.

Contraindication: Ceclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS, AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS TO BOTH DRUG CLASSES (INCLUDING ANAPHYLAXIS AFTER PARENTERAL USE).

Antibiotics, including Ceclor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs.

Precautions: If an allergic reaction to ceclor occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e.g., pressor amines, antihistamines, or corticosteroids.

Prolonged use of ceclor may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs test may be due to the drug.

Ceclor should be administered with caution in the presence of markedly impaired renal function. Under such a condition, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended.

As a result of administration of Ceclor, a false-positive reaction for glucose in the urine may occur. This has been observed with Benedict's and Fehling's solutions and also with Clinintest* tablets but not with Tes-Tape* (Glucose Enzymatic Test Strip, USP, Lilly).

Usage in Pregnancy: Although no teratogenic or antifertility effects were seen in reproduction studies in mice and rats receiving up to 12 times the maximum human dose or in ferrets given three times the maximum human dose, the safety of this drug for use in human pregnancy has not been established. The benefits of the drug in pregnant women should be weighed against a possible risk to the fetus.

Usage in Infancy: Safety of this product for use in infants less than one month of age has not been established.

Some ampicillin-resistant strains of *Haemophilus influenzae*—a recognized complication of bacterial bronchitis*—are sensitive to treatment with Ceclor.¹⁻⁶

In clinical trials, patients with bacterial bronchitis due to susceptible strains of *Streptococcus pneumoniae*, *H. influenzae*, *S. pyogenes* (group A beta-hemolytic streptococci), or multiple organisms achieved a satisfactory clinical response with Ceclor.⁷

Ceclor®

cefaclor

Pulvules®, 250 and 500 mg

Adverse Reactions: Adverse effects considered related to ceclor therapy are uncommon and are listed below. Gastrointestinal symptoms occur in about 2.5 percent of patients and include diarrhea (1 in 70) and nausea and vomiting (1 in 90).

Hypersensitivity reactions have been reported in about 1.5 percent of patients and include morbilliform eruptions (1 in 100). Pruritus, urticaria, and positive Coombs tests each occur in less than 1 in 200 patients.

Cases of serum-sickness-like reactions, including the above skin manifestations, fever, and arthralgia/arthritis, have been reported. Anaphylaxis has also been reported.

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients).

Causal Relationship Uncertain: Transitory abnormalities in clinical laboratory test results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician.

Hepatic: Slight elevations in SGOT, SGPT, or alkaline phosphatase values (1 in 40).

Hematopoietic: Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40).

Renal: Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200).

[1000000]

*Many authorities attribute acute infectious exacerbation of chronic bronchitis to either *S. pneumoniae* or *H. influenzae*.

Note: Ceclor* (cefaclor) is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

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Additional information available to the profession on request from Eli Lilly and Company, Indianapolis, Indiana 46285. Eli Lilly Industries, Inc., Carolina, Puerto Rico 00630

100061



QUESTIONS - ANSWERS

ROBERT J. RELIHAN, JR., Ph.D.
Iowa City, Iowa

STATUS OF TRANSPLANTATION

Mr. Relihan is administrative coordinator for the University of Iowa Organ Recovery Service. His comments constitute a status report on transplant activity in Iowa.

The Iowa Transplantation Program is now more than 10 years old. How does the program rank in national stature after this time?

The people of Iowa are fortunate to have located in their state one of the nation's finest renal transplantation services. In terms of the number of transplants performed, The University of Iowa Hospitals and Clinics ranks seventh nationally, and its patient and graft survival rates are consistently among those of the top centers in the country.

What brief statistics could you share to show Iowa transplant activity in 1980?

During 1980, 85 kidney transplants (8 of which were from living related donors) and one pancreas transplant were performed. Iowa's 500th kidney transplant took place on July 15, 1980. On January 31, 1980, an Iowa cadaver kidney transplant reached the ten-year survival mark for the first time. The service recovered 61 cadaveric kidneys, received 45 from centers outside the state, and shipped 17 to centers throughout the country. One kid-

ney was shipped to Prague, Czechoslovakia, and transplanted within 24 hours.

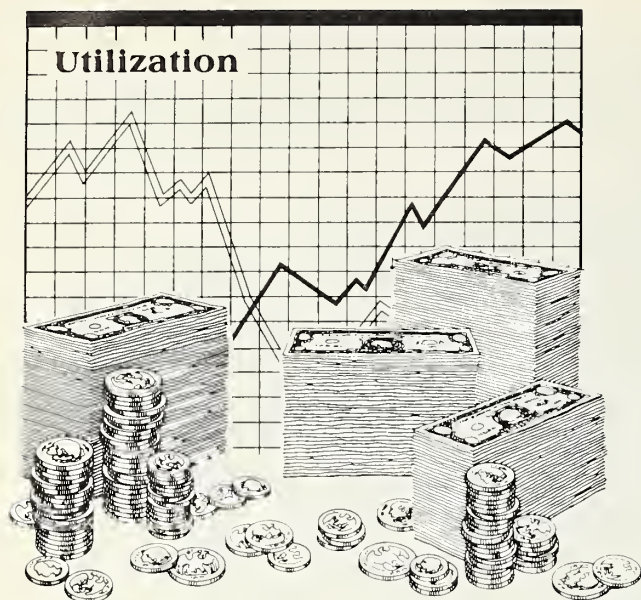
Is the availability of donor organs increasing at all to meet the demand?

Nationally, the trend over the past several years has been for the level of kidney donation to remain nearly constant and the demand for cadaver kidneys to rise. The demand is expected to increase for at least the next four years. The University of Iowa mirrors this trend. At present, there are 50 patients on our list of those awaiting cadaver renal transplants. While the number of transplants at Iowa rose 25% last year, the number of kidneys recovered in the state grew by only 5%. We were fortunate, however, in being able to import 61% more kidneys from outside centers as a result of our participation in computerized organ sharing systems. Since even the most optimistic estimate places the number of actual kidney donors at only 35% of the potential suitable donors, it is possible to increase the number of kidneys donated in Iowa. This increase will affect positively graft and patient survival at Iowa in 2 ways: ischemic times will be shorter than those of kidneys from outside centers and we will be able to perform with greater regularity more successful DR tissue matching procedures, which are performed at only a few outside centers.

What can Iowa physicians do to aid the retrieval of organs, recognizing the complexity and sensitivity involved?

Iowa physicians can do 3 things: they can make their support of organ donation known in their communities, even on a most informal level; they can encourage the development of more active donor identification and referral procedures in their community hospitals; they can refer their patients, who meet the criteria, as kidney donors. This final point, involving, as it does, explaining organ donation to the families of their patients, can be one of particular delicacy, particularly for the family physician, for whom the death of a patient of long-standing may seem a personal tragedy. Experience and research have shown, however, that organ donation is most often a genuine positive comfort to the surviving family members.

(Please turn to page 66)



Let's solve this dilemma.

Recent discussions among many groups of providers across the state have led to a recognition that the state's rate of inpatient hospital utilization ranks among the highest in the nation.

In support of cooperative efforts to identify and control the reasons for this situation, Blue Cross and Blue Shield of Iowa are endorsing physician and hospital efforts to control utilization by requiring member hospitals to perform Utilization Review and eliciting physician support for this action.

As part of Blue Cross and Blue Shield of Iowa's commitment to cost containment, we have included medical necessity criteria in subscriber contracts, eliminated the sale of diagnostic admission riders to our contracts, expanded diagnostic, x-ray and laboratory (DXL) benefits to 800,000 Iowans, and worked with the Foundation in developing a list of outpatient surgical procedures.

WE SHARE YOUR CONCERN FOR QUALITY CARE

Your support of cost containment measures such as utilization review will:

- Place the decisions of medical necessity into the hands of physicians, through the peer review mechanisms of local hospitals and the IFMC.
- Help reduce costs by eliminating unnecessary hospital stays and monitoring length of stay.
- Show your support of private sector initiatives in controlling health care costs.

Reducing expenses associated with high utilization is a responsibility that must be shared by the health care community as a whole.

We encourage your support of these programs which strive to make quality health care attainable and affordable.



**Blue Cross
Blue Shield**
of Iowa

Improving Survival Rates in Renal Transplantation

ROBERT J. CORRY, M.D.,
NANCY E. GOEKEN, Ph.D.,
DAI D. NGHIEM, M.D.,
LAWRENCE G. HUNSICKER, M.D., and
LOUIS ERCOLANI, M.D.
Iowa City, Iowa

This current report shows Iowa kidney transplant survival rates continuing to improve for both cadaver and living related grafts. Also emphasized is the need for an increased supply of cadaver kidneys to meet the increasing population of potential recipients. The Iowa Transplantation Service has gained a reputation as one of the nation's finest.

SINCE OUR last report in this JOURNAL, in November 1978, significant developments have occurred in transplantation. These developments have led to improved renal transplant survival rates, and thus, a better quality of life for our patients. In addition, an increase in the acquisition of cadaver kidneys from other centers in the United States has resulted in an overall increase in the transplantation of better matched kidneys at The University of Iowa (Figures 1 & 2).

CADAVER TRANSPLANTATION

Better results in cadaver transplantation at this center can be attributed essentially to 3 factors.

The authors are associated with the Transplantation Service at The University of Iowa College of Medicine.

First, since April 1979, our center has been one of only a few in this country and Europe to have a policy of prospective selection of recipients based on HLA-DR antigens. DR antigens are defined by lymphocytotoxicity assays using B-lymphocytes as the targets. These antigens were found to be closely associated with the mixed lymphocyte culture (MLC) reaction and thus were more predictive of actual graft outcome than the more traditional HLA-A and B antigen matching using T-lymphocytes as targets. A major advantage in using DR matching to select donor-recipient pairs is the fact that only a single locus (2 possible antigens per individual) is involved in determining HLA-DR type as compared to 2 loci (4 possible antigens) in traditional typing. In addition, the DR system has less polymorphism, so that not only can better matches be obtained, but the

THE SCANLON MEDICAL FOUNDATION/IOWA MEDICAL SOCIETY HAS DESIGNATED THIS ARTICLE AS THE HENRY ALBERT SCIENTIFIC PRESENTATION FOR THE MONTH OF FEBRUARY 1981.

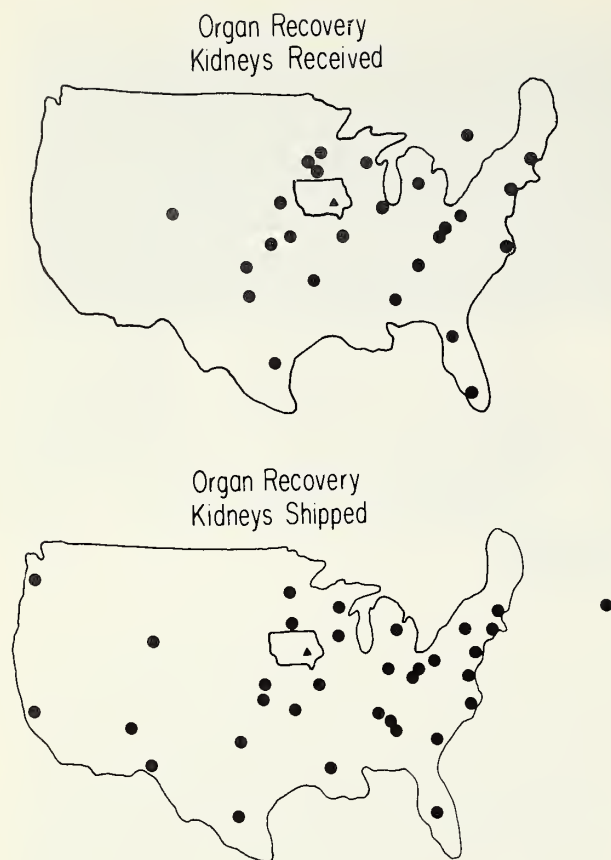


Figure 1. Points on top map show origins of donor kidneys which have been recovered outside of our region and sent to The University of Iowa for transplantation. Bottom map illustrates locations where Iowa kidneys have been sent for transplantation. Point to the right of Maine is supposed to represent a successful transplant in Prague with an Iowa kidney.

waiting time for transplantation can be significantly reduced. Our own center has shown a 42% increase in cadaver transplantation comparing the periods of 4/1/78-4/1/79 to 4/1/79-4/1/80. Preliminary results have shown that no kidneys have been rejected when matched for 2 DR antigens (the best possible match). There is a 76% one year graft success rate when matched for a single DR antigen.¹

Second, the beneficial effect of recipient blood transfusion on transplant outcome continues to be a major factor associated with an improved graft success rate. The blood transfusion issue is complex in that intentional "priming" of recipients with random blood transfusions prior to transplantation carries the real risk of sensitizing large numbers of potential transplant recipients against a significant number of HLA antigens. In other words, broadly

reactive cytotoxic antibodies directed against HLA specificities may be stimulated by transfusion of blood products. These antibodies might delay or preclude transplantation altogether. Thus, the potential benefit might not be worth the price. However, we² and more recently the group at Oxford, England³ have shown almost the same beneficial effect of blood transfusion administered during the transplant operation as achieved by preoperative transfusion (Figure 3). Obviously, intraoperative blood transfusion cannot sensitize the recipient against the first transplant. To evaluate the risk of sensitization and the value of intraoperative transfusion, we have initiated a randomized study involving several of the major transplant centers in the United States.

Third, although the benefit of newer pharmacologic immuno-suppressive regimens have not been fully evaluated, promising preliminary results have been noted. Cyclosporin A, an antifungal metabolite, has been tested the last 2 years by the Cambridge group and preliminary results are encouraging.⁴ However, the drug is such a potent immunosuppressive agent, that infection has been a major deterrent, and polyclonal lymphomas have been recorded in some patients receiving this drug.⁴ Heterologous antithymocyte globulin (ATG) is another well established immunosuppressive agent in the laboratory. In our laboratory, rabbit anti-mouse ATG, used alone, has extended the survival of primarily vascularized rat heart xenografts in mice from 5 to more than 50 days.⁵ However, it has not proved to be as effective in humans when it is used prophylactically. Several randomized studies in humans conducted in the last 10 years have failed to show a major beneficial effect of this drug. More recently though, when the drug has been used to treat rejection reactions, the effect has been quite dramatic. The crux of the matter is that in 60 to 70% of the patients, ATG is not needed; its use should probably be reserved for the patients who experience a severe, but potentially reversible, rejection reaction. In contrast to Cyclosporin A, its safety factor is not a problem in that mortality is the same in those patients who received ATG compared to those who did not. In fact, patients receiving ATG have usually received a much lower total dose of steroids. We have used ATG to treat severe rejections in 10 patients with reversal of rejection in 8 of these patients. Approval by the

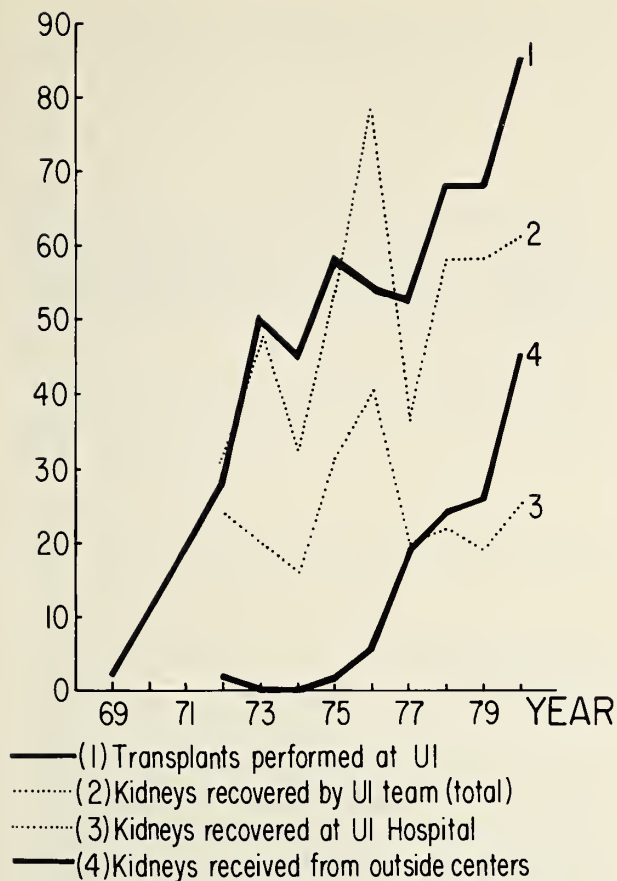


Figure 2

FDA for ATG is imminent. For Cyclosporin A, approval will undoubtedly await more extensive laboratory and clinical trials.

The combined effect of favorable factors has been shown to be additive and in some cases even more than additive. For example, in our center, transfused recipients who received a kidney matched for a single DR antigen have a graft survival approaching 90%. Similarly, transfused patients who receive a kidney from a cadaver donor "pretreated" with high doses of Cyclophosphamide and Methylprednisolone to kill passenger or "sensitizing" lymphocytes of the graft, have a survival of 85% at one year in our center.

LIVING RELATED TRANSPLANTATION

Transplantation from a well matched living related donor still offers the patient the best chance of long-term success. Graft survival at 3 years following transplantation has improved from 68% to 86% when comparing an earlier

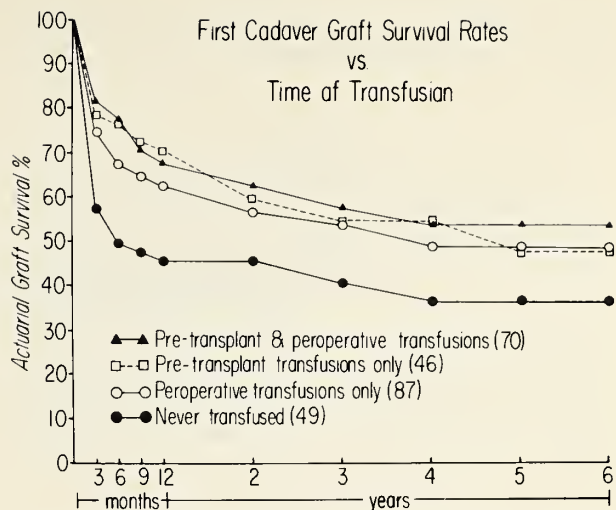


Figure 3. Favorable effect of pre-transplant and peroperative (intraoperative) blood transfusion on graft survival rates (April 1973 to May 31, 1980).

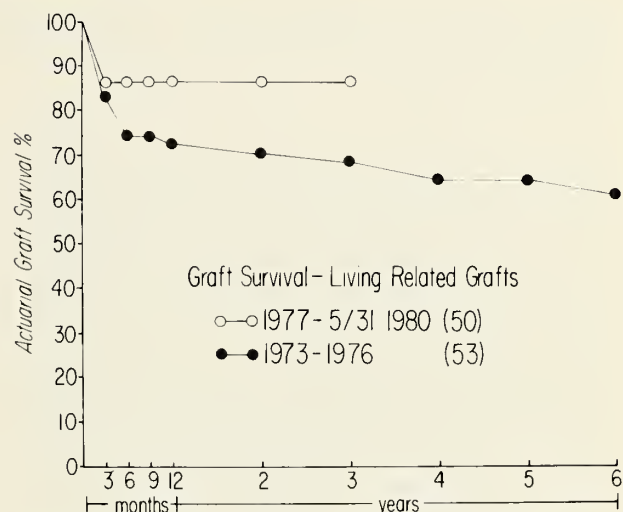


Figure 4. Improved graft survival rates in the living related transplants since 1977.

group of 53 patients with the more recent 50 patients (Figure 4). This improved success has been attributed in a large part to donor selection based on a low (MLC) reaction. Since cadaver transplant survival has improved, we have excluded as donors those family members who have even moderately high MLC responses. We routinely repeat all MLCs on non-identical donor-recipient pairs who are being considered for transplantation since the "responder" status of the patient can depend in part on a host of minor physiological variables such as viral infection or drug ingestion. Mortality for recipients of live donor kidneys has

(Please turn to page 64)

been negligible as a result of the decreased requirements for prolonged antirejection therapy.

SUMMARY

This report illustrates the improving trend in renal transplant survival rates for both cadaver and living related grafts. It also underscores the need for an increased supply of cadaver kidneys to meet the increasing population of potential recipients originating in Iowa and adjacent states as well as those referred here from other areas. As survival rates continue to improve at this center, consideration should be

given to the transplantation of organs other than the kidney in the near future.

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REFRESHER COURSE FOR THE FAMILY PHYSICIAN

MARCH 10-13

The 1981 Refresher Course for the Family Physician will occur in Iowa City March 10 to 13 under sponsorship of the University of Iowa College of Medicine, the Department of Family Practice, and the Iowa Academy of Family Physicians.

The FP Refresher Course is accredited for 26.5 hours by the American Academy of Family Physicians and for the same amount of Category I credit toward the AMA Physicians' Recognition Award. The University of Iowa awards 2.6 Continuing Education Units for the full program. Additional information is available from the Office of Continuing Medical Education, U. of I. College of Medicine, Iowa City, Iowa 52242. Telephone: 319/353-5763.

The 1981 Refresher Course will give family physicians a stimulating and practice-oriented look at what is new in medical thinking, and a chance to brush up on what is old. Practical applications will be emphasized. Brief lectures, panels, small-group discussions and workshops, question and answer periods, lunches with the experts, printed course syllabuses, self-assessment quizzes, basic CPR certification — all of these will be available in a fast-

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Unless you are currently certified in basic cardiopulmonary resuscitation, registrants are urged to become certified while attending the course.

Because of the favorable response to last year's offering of physician examinations to the registrants, the opportunity to have a complete physical examination will be repeated again this year. Advance notice of appointments will be mailed to the participants.

Among the 1981 program topics are *Helping the Common Pain-in-the-Neck, Vaginal Flora and Toxic Shock Syndrome, Management of Otitis Media: New Wrinkles, Newer Anti-Inflammatory Agents for Treating Arthritis, Control of Chronic Pain, What Is Biofeedback and What Can It Do? "The Third Wave" — Family Practice of the Future, Aspirin (or Something) for Impending Stroke, The New Insulins, Problems in Sports Medicine, Myocardial Infarction, Indications for Ordering a CT Scan, and The Treatment of Insomnia.*

Registrants' spouses are cordially invited to attend. The program begins at 8:15 a.m. on Tuesday, March 10, and continues until adjournment at 1:15 p.m. on Friday, March 13.

Arthroscopic Knee Surgery

PETER D. WIRTZ, M.D.

Des Moines, Iowa

Increasing use is being made of arthroscopy in the surgical care of knee conditions. The author describes this progress briefly. He emphasizes the postoperative benefits by highlighting two cases.

KNEE ARTHROSCOPY has improved rapidly to the point where its use as a diagnostic aid is commonplace. Arthroscopic surgical removal of tissues is likewise becoming readily available.

Arthroscopy is useful in making a diagnosis when there is a confusing clinical picture. When the precise nature of an internal knee problem is not evident after a routine workup — history, physical and routine x-rays — it is probable that arthroscopy can be helpful in devising a therapeutic approach. Contraindications to arthroscopy include local and systemic sepsis.

Whereas diagnostic arthroscopy is done with a small endoscope and may be performed under local anesthesia, operative endoscopes and instruments are of such a size to require a spinal or general anesthesia. The instrumentation for arthroscopy surgery ranges from 3 to 5 mm for the scissors, grasping forceps, biopsy punches and knives. Newly developed motorized equipment is used on the synovium, with a rotating cutting device utilized for articular and meniscal cartilage. This system requires an external negative pressure to allow

the tissue to be sucked into the cutting device for sectioning. This type of instrumentation usually requires a two portal technique for surgery. The operating endoscope has an offset eye-piece. It has a central operating channel for the 3 mm instruments for resection and affords vision by a one portal operative technique.

These procedures are performed in an operating room under an aseptic technique. A thorough diagnostic evaluation is made at the beginning of all cases, even those having had a prior diagnostic arthroscopy under local anesthesia. The 4 main parts of a diagnostic exam include the medial compartment, the intercondylar notch, the lateral compartment, and the patellofemoral joint and suprapatellar area. A probe or a fifth nerve hook is useful in manipulating menisci or synovium to help in diagnosis.

Arthroscopic surgery lends itself to synovial biopsy, meniscectomy, smoothing articular cartilage, assessing ligament damage and retinacular surgical release. Often a direct visual biopsy of abnormal synovial tissue will be more precise than a blind technique. Meniscal tears that require surgical removal are readily evident under direct vision and lend themselves to adequate removal. The bucket handle tear is removed through the endoscope incision after anterior and posterior detachment. Vertical, horizontal and transverse tears require saucerization to stable peripheral meniscal tissue. Articular cartilage degeneration is easily

The author is in the private practice of orthopedic surgery in Des Moines, Iowa.

smoothed with motorized instruments, but the results of this surgery are not as rewarding as might be expected.

Ligament integrity may be assessed with arthroscopy. The anterior cruciate ligament is easily seen whereas the collateral ligaments are extra articular. The posterior cruciate ligament is seen from the posterior medial approach and, as in any ligament, if there has been an acute injury, there will be hemorrhage into the surrounding tissues. Loose bodies can be identified, grasped and removed through small incisions. Symptomatic medial synovial plica are sectioned or excised. Patellar malalignment problems causing pain about the knee may be aided by retinacular release with arthroscopic control.

The main surgical advantage is reduced morbidity and shorter hospitalization. Most patients are able to walk upon awakening from anesthesia and with continued exercising can be back to many routine activities in one week. Because of the rapid return to activity many of these procedures are done on an outpatient basis or with discharge occurring the day after surgery.

CASE SUMMARIES

Here are two brief case summaries:

G.F. is a 17-year-old male who suffered an original valgus knee injury playing football in 1978. Following rehabilitation, he played in the 1979 season, but while wrestling on 11/29/79,

he sustained a twisting injury and a locking of the knee joint. On 12/21/79 the patient underwent arthroscopy which revealed him to have a lateral bucket handle tear then in anatomical position. He had an arthroscopic surgical removal of the torn bucket handle tissue and was discharged on 12/22/79. He returned to full activity, including a paper route, on 12/23/79. Orthotron Quadriceps testing on 1/7/80 showed 96% strength as compared to his opposite quadriceps.

B.P. is an 18-year-old male who was injured in 1978 by a football clip. He was rehabilitated through the season. In the 1979 season he began noting a snap in his knee joint. His exam showed thigh atrophy, full range of motion, slight swelling, as well as anterior drawer that impinged his medial meniscus. On 12/18/79 arthroscopy showed him to have an old anterior cruciate ligament rupture, a displaced bucket handle tear of the medial meniscus, and a lateral meniscal vertical split tear which were both corrected by arthroscopic surgery. He was discharged 12/19/79 and Orthotron Quadriceps testing on 1/3/80 showed strength at 92% of normal.

These 2 cases demonstrate that postoperatively there is less muscle inhibition so that strength and endurance loss is minimized. A knee effusion is present for about 3 weeks, but this does not limit flexion activities.

It is expected the long term results of arthroscopy and arthroscopic surgery will be better than conventional arthrotomy methods.

QUESTIONS/ANSWERS

(Continued from page 59)

Did 1980 see any research breakthroughs in the transplant area?

There has been progress in the development of more precise immuno-suppressive regimens. We are now using antithymocyte globulin to combat rejection and early evidence indicates that it is more effective than other im-

munosuppressive drugs. More centers, including The University of Iowa, are relying on DR matching of donor and recipient in addition to the standard HLA system. Since a "perfect" DR match requires donor/recipient identity of 2 antigens, while such an HLA match requires 4, and there is little significant difference between graft survival rates of DR and HLA "perfect" matches, DR matching permits statistically the more frequent occurrence of better matched donors and recipients. Finally, we are electively transfusing our patients on a regular basis since this, too, improves graft survival.



COMMENTING EDITORIALY

MARION E. ALBERTS, M.D.
SCIENTIFIC EDITOR

OUT OF (AND INTO) THE MOUTHS OF BABIES

The eating habits of children are a common discussion subject between pediatricians and parents. Several years ago a mother told me her child simply would not eat. In a rather emphatic manner she exclaimed, "Doctor, you do not understand; he won't eat anything, period!" The little boy was standing nearby apparently unconcerned about his mother's worries. He chimed in, quite revealingly, and shouted, "But, Mom, I don't like periods!"

Despite efforts by mothers to provide good foods for their children, there often is a perpetual feud during mealtime. Until the mother learns to understand the normal behavior of her child, unhappiness about his or her intake will go on and on.

A dilemma often arises in dealing with chil-

*Bulletin of National Clearinghouse for Poison Control Centers, Vol. 24, No. 6, June, 1980.

HYPERACTIVE ADULTS

PEDIATRICIANS are aware that some children have an overabundance of energy. We know, too, this can precipitate behavioral and learning problems. Such children have been labelled *hyperactive*, *hyperkinetic*, *minimal brain dysfunction*, and, more recently, we have heard

dren. On one hand, the mother expresses concern that her child will not eat, and on the other hand, children consume an abundance of "junk" food provided by the parents. Ironically, the parents provide the undesirable foods, all the while wondering why the child prefers this form of sustenance. Furthermore, ingestion of poisonous substances is greatest among these same children, plants being the most common product ingested by those under 5 years of age. Completing the top 5 unsafe categories are (2) soaps, detergents, cleansers, (3) perfume, cologne, toilet water, (4) antihistamines, cold medications, and (5) vitamins, minerals. During 1977, the National Clearinghouse for Poison Control Centers processed 156,330 case reports from 340 poison control centers.* The aforementioned 5 categories amassed 28,457 case reports (almost 30% of all cases in this age group).

Among the plants ingested, philodendron and dieffenbachia were most frequent; PineSol and Comet topped the second category; and Congespirin and Contac headed the antihistamine/cold medications classification.

These data indicate we must be stronger in our admonitions about harmful ingestants. Counseling on child behavior must emphasize the dangers here. It is incumbent upon us to discuss the common harmful substances which are available to children; to boot, we must make straightforward admonitions about providing so many "junk" foods. Parents often need to change their own eating habits to make undesirable foods less available. Our children will be more healthy, the costs of feeding the family will decrease, and there will be less ingestion of poisonous substances if we put our minds to it. — M.E.A.

it said they are afflicted with an *attention-deficit disorder*.

Much has been reported about the manifestations of these children. It is known they require specialized education, more personalized day-to-day guidance, and drug therapy in some instances. Furthermore, many proposals have been made as to the role of diet and food additives. All the proposals are not without

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EDITORIALS

(Continued from page 67)

questions about controlled studies or whether the observations are really valid. Some children are truly more active when given an abundance of sugar. Yet, there would seem to be a more basic physiologic function in this behavior pattern, for many children can eat large amounts of sugar and such ingestion results in greater weight gains. There must be a variation in metabolism which converts the sugar to instant energy for some while others store it as fat.

The American Psychiatric Association now recognizes that similar hyperactive overt behavior occurs in adults. It has been reported that the adult form of attention-deficit syndrome is a distinct diagnosis different from other behavior disorders such as schizophrenia. There are strong psychologic factors at work in these patients so that extensive coun-

selling is necessary over and above the dietary restrictions and the use of drugs. These adults show the same paradoxical responses to stimulant drugs such as methylphidate and dextroamphetamines. Some adults recognize their problem and learn to adapt to life without specific treatment. Some, however, become alcoholics, child-abusers, fight constantly with their family and friends, or periodically sink into deep depression. They may have a short attention span, and experience difficulties in holding jobs. Crime often becomes their outlet. The diagnosis is not easy because the overt symptoms are so varied. In some instances the diagnosis is identified in the parent while considering the hyperactivity of the child.

Attention-deficit disorder must be considered in the adult with overt behavioral characteristics. Mood altering drugs of the sedative and tranquilizing nature may be detrimental. The paradoxical reaction from a stimulant may help, along with counselling, to aid the patient to become a happier and more productive member of society. — M.E.A.

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LETTERS TO EDITOR

Dear Editor:

Regarding your article "In the Public Interest — Kudos to Family Practice," page 534, December, 1980, JOURNAL OF THE IOWA MEDICAL SOCIETY, I would like to make a comment. Of the 59 Iowa communities where one or more graduates of the SFPTP (Statewide Family Practice Training Program) have located, nearly 80% are north of Interstate 80. This suggests that future graduates might look to the southern half of Iowa for good opportunities. — *Don N. Orelup, M.D., Albia*

Dear Editor:

I would like to respond to your article of January 1981 pertaining to Phenothiazine in-

duced Keto-Acidosis, particularly the suggestion in the closing remarks that the Chlorpromazine was the major factor in this patient's development of Keto-Acidosis. I would suggest that any time that a patient is given a dose of 1200 mg of Thorazine daily in addition to 100 mg of Prolixin intramuscularly on a weekly basis that one is producing a situation which has the potential of being much different than the run of the mill side effects. Both of those dosages are quite high although may well have been indicated in a severely psychotic patient. When a combination of Phenothiazines is given it often times will cause adverse side effects which might otherwise not have been seen and especially in such large dosage. It would seem to me that the culprit in this case may not have been just the large dosage of a single Phenothiazine but the large dosage of two Phenothiazines in combination. I appreciate the intent of the article and feel that the reminder is well worth the effort put forth. — *Ronald L. Bendorf, M.D., Council Bluffs*

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OUR MAN ON EDUCATION

RICHARD M. CAPLAN, M.D.

BIG BERTHA

PERHAPS YOU will remember "Big Bertha," the affectionate name for the largest cannon used on the Franco-German battle lines during World War I. Folks at the time were very impressed with the weight and destructive power of the missile, the distance it could be propelled and the accuracy possible with that weapon. From today's military standpoint, that the pride of the times arose from such accomplishments is a measure of how primitive was their technology. For now we have missiles that are target-seeking and self-correcting. How fabulous to be able "to shoot an arrow in the air," and instead of completing the couplet with "It fell to earth I know not where," to complete it thus (with proper homage to Ogden Nash): "It fell to earth precisely where I wanted it to because the radar and the computerized light, heat and radiation sensors in its nose cone took it there."

One of my biggest problems and frustrations as a CME planner (and I believe this is true of all thoughtful CME planners) is my sense that the physicians and educational offerings I'm involved with are Big Berthas. We try to devise an instructional package that will hit the mark, and we send it on its way — but too seldom do we know where the mark is, or whether there even is one. That is, how do we know if an educational need exists, or precisely who has that need? And individual physicians are a party to this conundrum, too. It makes lots of

sense that a physician should prefer to be engaged in educational pursuits that relate to his needs — either needs that he feels (gut reaction) or needs he has determined through some effort made to examine his own practice, his patients and their health outcomes. But even if it makes sense, only a small number do it.

We speak of the self-directed and self-correcting learner as the ideal in continuing education. A "newfangled cannonball" can guide itself and change its course in mid-air through the marvelous measurement and guidance systems housed in it. Correspondingly, a physician needs to make analogous measurements of where he is, what his needs are, and how to steer his educational trajectory to the end he desires, rather than merely put in some time on miscellaneous efforts.

Another example of self-directing modern technology is the "artificial pancreas" now working well in diabetic dogs — a tiny implant-

"... a physician needs to make analogous measurements of where he is, what his needs are, and how to steer his educational trajectory . . ."

able chemical assay unit that constantly monitors blood glucose level and just as constantly releases into the circulation that precise amount of insulin that will hold the glucose value at the desired level. I doubt that the educational/learning process can ever become so precisely self-monitoring and self-correcting, but present educational and health-care delivery assessment techniques are now well enough developed that we could at least do a much better job than many of us now do. That may sound like a "Brave New World" with its frightening connotations, but let's not forget all the fine advances available to us in such a world.

If each physician were to become his own self-directed, self-assessing, self-correcting learner, then what would all CME planners and DME's do? No problem: just as there must be those who build the self-correcting missiles and the self-controlling insulin-release systems, so there will need to be CME leaders of the future, to teach the physicians how to be self-studying and self-correcting in behalf of improved patient care and health outcomes.

Dr. Caplan is Associate Dean for Continuing Medical Education at The University of Iowa College of Medicine.

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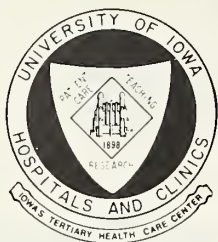
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DRUG THERAPY REVIEW



UNIVERSITY OF IOWA HOSPITALS AND CLINICS

REYNOLD SPECTOR, M.D., Editor

TREATMENT OF MODERATE & SEVERE CHRONIC PAIN SYNDROMES WITH MORPHINE & ADJUNCTIVE DRUGS

THE TREATMENT of moderate and severe chronic pain syndromes in the past has frequently been unsatisfactory. However, in recent years, several groups of investigators have provided new information that, if utilized, provides for substantial improvements in the treatment of serious, chronic pain syndromes. This article is to review the therapeutic uses in chronic pain syndromes of: 1. narcotics alone; 2. narcotics combined with central stimulants such as amphetamines, cocaine, or doxapram; and 3. narcotics combined with phenothiazines or antihistamines. Recent pharmacokinetic data that are useful in understanding and preventing adverse reactions to narcotics are also reviewed. The use of narcot-

ics with other drugs (e.g., antidepressants) is not discussed since there is inadequate information to justify their use as adjuncts to narcotics in the treatment of pain.

PHARMACOKINETICS

Over the past few years, several important points about the pharmacokinetics of morphine and other narcotics have emerged.^{1, 2} First, morphine, meperidine and, to a lesser but still significant extent, methadone are metabolized in the liver. Only approximately 33% of morphine and 50% of meperidine reach the central circulation after oral dosing in normal volunteers, largely because they are metabolized by the liver before reaching this point. Consequently, larger oral doses of morphine or meperidine need be given to achieve equianalgesia with parenteral drug. Second, there is a rough correlation between analgesic potency, side effects (e.g., respiratory depression) and plasma levels of morphine and meperidine in nontolerant subjects. In the case of methadone, peak analgesia occurs several hours before peak plasma levels. Thirdly, as would be expected in both acute and chronic liver disease, the dose of narcotics may need to be reduced substantially because of decreased liver metabolism. In patients with hepatic precoma, narcotics are especially dangerous. Finally, there is decreased clearance and a longer half-life of morphine and meperidine (normally 2 to 4 hours) in older patients. This may explain the increased sensitivity of elderly patients to narcotics.

It is well known that of the currently marketed parenteral analgesics, none (including heroin) exceeds the effectiveness of morphine. Others may be more potent by weight and have different pharmacokinetic properties but none are better for the relief of pain. Unfortunately, morphine and other strong analgesics can cause serious undesirable effects such as sedation, nausea, vomiting, constipation, addiction, respiratory depression, biliary tract spasm, impaired cough reflex, and others. In an attempt to alleviate some of these problems, various combinations of opiates and opioids with other pharmacological agents have been recommended with the claim that they are equally effective as morphine alone but produce fewer or less severe adverse effects. In

This information for Iowa physicians is furnished and sponsored by the University of Iowa Hospitals and Clinics.

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DRUG THERAPY REVIEW

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most cases, however, these claims are not well founded.

NARCOTIC-STIMULANT COMBINATIONS

Forrest *et al*³ have demonstrated in a double-blind, single-dose study that postoperative patients with pain can benefit from the use of intramuscular dextroamphetamine combined with morphine sulfate. The combination of 5 and 10 mg of dextroamphetamine with 3, 6, and 12 mg of morphine generally produced greater relief of pain than the same dose of morphine alone. The incidence of sleepiness attributed to morphine was significantly decreased when combined with dextroamphetamine, although sweatiness was significantly increased. Alertness also showed a significant dose-related improvement with the use of dextroamphetamine.

It is conceivable that other central nervous system stimulants such as doxapram and cocaine also could produce greater alertness and analgesia when combined with strong analgesics. A double-blind, controlled study⁴ of intravenous doxapram with morphine demonstrated no significant differences in pain relief, PaO₂, and PaCO₂. Small but significant ($p < 0.05$) improvement was observed in minute volume.

The combined use of morphine and cocaine in the management of the pain of advanced cancer was reported as early as 1896. In 1952 the Brompton Hospital introduced a formulation into the British National Formulary containing morphine and cocaine in a hydroalcoholic solution, the so-called Brompton Cocktail. Many alterations in this formula have occurred, including the substitution of heroin or methadone for morphine and the addition of a phenothiazine. Several reports have described the successful use of the Brompton mixture in the management of intractable pain of malignancy; however, until recently, properly designed clinical trials to determine the benefits of the Brompton mixture had not been conducted.

Melzack⁵ in a double-blind, crossover study demonstrated that the standard Brompton formulation (morphine plus cocaine in a hydroal-

coholic vehicle) offered no greater pain relief than morphine alone. Both formulations relieved pain in about 85% of the patients studied. Also, a randomized, controlled comparison of morphine and heroin elixirs, with and without cocaine, has shown that the addition of cocaine, although increasing alertness in some patients, contributes little to the analgesic efficacy of the product.⁶ Although the amount of cocaine in the traditional Brompton mixture is quite small (10 mg per dose), it has been shown that "highs" can be attained with larger (2 mg/kg) oral doses.⁷

As a result of these studies and the occasional inability of manufacturers to supply the cocaine, the Brompton mixture formulation currently available at The University of Iowa Hospitals and Clinics is a hydroalcoholic solution containing only morphine sulfate. The liquid dosage form may facilitate the administration of analgesics to patients who have difficulty swallowing or have nasogastric tubes in place.

The data concerning the advantages of such combinations are not convincing and we believe the major indication for using the morphine-dextroamphetamine combination is when analgesic-induced central nervous system depression (e.g., excessive sedation) is produced in a patient for whom alertness is important. Forrest *et al*³ utilized intramuscular dextroamphetamine, a form not currently marketed, and it is unclear whether the oral preparation will produce equivalent results. The shortcomings of doxapram, in addition to those previously mentioned, are its very short duration of action and its availability only in parenteral form. Significant benefits have not been demonstrated for other analeptic combinations.

NARCOTIC-PHENOTHIAZINE COMBINATIONS

The use of phenothiazines as analgesics or potentiators of analgesics continues in most cases to be a popular fantasy.⁸ Numerous studies have compared them with known analgesics, but most suffer from improper study design and/or deficient data analysis.

All of the double-blind clinical trials exploring the analgesic effects of promazine, promethazine, and propiomazine alone and in combination with narcotic analgesics or aspirin

(Please turn to page 76)

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DRUG THERAPY REVIEW

(Continued from page 74)

have demonstrated that the phenothiazines were ineffective. Likewise, the only published double-blind study comparing the use of chlorpromazine alone or in combination with strong analgesics (i.e., meperidine, morphine) does not support the use of this agent as an analgesic or analgesic potentiator.

Methotrimeprazine (MTZ), on the other hand, has been more extensively studied in ten double-blind trials.⁸ Although most of these studies had major design deficiencies and did not include chronic use, the weight of information tends to indicate that methotrimeprazine may have some intrinsic analgesic activity. However, the analgesic activity of MTZ may be attributed to sedative effects rather than pain relief and attempts to separate the two pharmacological effects have not been attempted. Analgesic activity of other phenothiazines has not been examined in a double-blind manner.

Methotrimeprazine and other phenothiazines can produce nearly as many toxic effects as narcotic analgesics and include sedation, hypotension, and extrapyramidal symptoms. For these reasons alone, it is usually inadvisable to use them in the treatment of chronic pain. Phenothiazines are usually helpful for the nausea and vomiting associated with the use of narcotic analgesics; however, not all patients will experience this problem and it is recommended in most cases that they not be administered until gastrointestinal complaints have been documented.

NARCOTIC-HYDROXYZINE COMBINATION

Hydroxyzine, an antihistamine, has been touted as an analgesic and analgesic potentiator.^{9, 10} The published studies involve the treatment of postoperative and obstetric pain and, for the most part, are single-dose trials. All have serious deficiencies such as the absence of a placebo group, incomplete reporting of results, and insufficient doses of compared analgesics. The most recent report⁹ indicates that 75 mg of hydroxyzine produced greater pain relief than 150 mg of hydroxyzine, but 10 mg of morphine was significantly more analgesic ($p < 0.05$) than the larger dose of hydroxyzine. The combination of hydroxyzine

plus morphine also produces more sedation than morphine alone.

From the available data, it is not evident that the combination of hydroxyzine and strong analgesics will permit the use of smaller doses of the latter for equivalent pain relief. Likewise, there are no convincing data demonstrating that hydroxyzine has intrinsic analgesic properties.

RECOMMENDATIONS

In general, we do not recommend the routine use of combination products for the aforementioned reasons. However, the use of combinations of morphine (or methadone) and amphetamine in patients with excessive narcotic-induced depression (e.g., drowsiness, stupor) may allow such patients to have adequate pain relief and become sufficiently alert, for example, to write a will. Phenothiazines are usually beneficial for the patient who has experienced narcotic-induced nausea and vomiting. They also may be helpful when used prophylactically in the less frequently occurring situation when vomiting may be unusually harmful to the patient.

Parenteral morphine remains the gold standard for analgesics and should be administered in adequate doses and at sufficient intervals to relieve pain. Addiction usually is not a problem in short-term use (postoperative) and should not be a justification for inadequate analgesia in terminally ill patients. — MICHAEL R. ALEXANDER, M.S., *Pharmacy Department, VA Medical Center*; STEPHEN C. BERGQUIST, M.S., *Pharmacy Department, U. of I. Hospitals and Clinics*, and REYNOLD SPECTOR, M.D., *Professor of Medicine & Pharmacology, U. of I. Hospitals and Clinics*.

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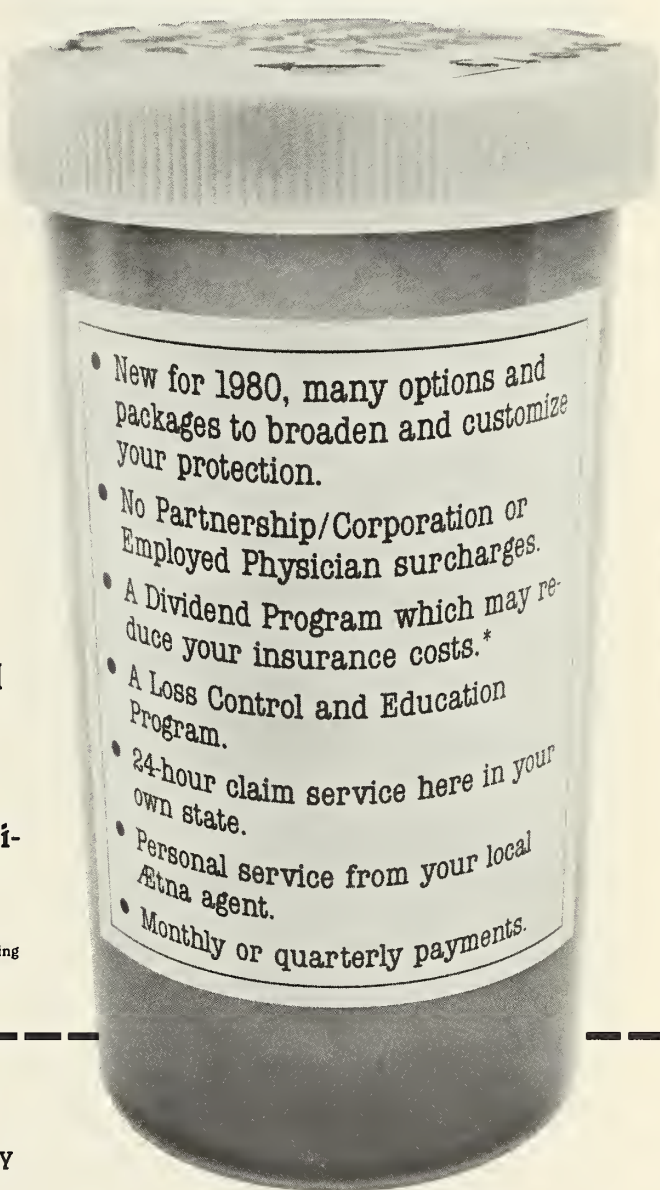
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SCABIES IN INSTITUTIONS

During the last 2 years, scabies has been diagnosed in 2 state institutions, 4 nursing homes, and in an undetermined number of preschool nurseries in Iowa. Once introduced, scabies is transmitted to both residents and staff because of the extensive hands-on care and the nature of a facility, i.e., an extended household.

Control measures are most effective if all staff and residents are treated with an approved scabicide. Two treatments a week apart are recommended for symptomatic personnel. Household contacts of symptomatic staff should also be treated; once if no lesions are present and twice if lesions and pruritus are present. These are guidelines and should be amended if necessary.

In older children and healthy adults, lindane lotion and cream (Kwell) or crotamiton (Eurax) may be used for therapy. Preschool children or elderly individuals with dry sensitive skin should be treated only with crotamiton. Alternatively, 5-10% sulfur in petrolatum may be used for treatment. A standard regimen is 6% precipitated sulfur, 3% balsam of peru in petrolatum. Apply from neck on down daily for 3 consecutive days and precede with bath and remove final treatment with a bath 24 hours later. While this product is greasy and odoriferous, it is very effective and non-toxic.

This information on public health matters is furnished and sponsored by the Iowa State Department of Health.

TABLE I
SUGGESTIVE AND DIAGNOSTIC FEATURES OF SCABIES

Suggestive Features
Distribution
Morphology
Burrows are pathognomonic, but are seen less frequently in the current epidemic
Nocturnal pruritus
Contact cases
Response to "specific" therapy
Skin biopsy in inflammatory and nodular lesions
Diagnostic Features (identify the mite)
Microscopic study of skin scrapings
Skin biopsy
Sections (multiple usually required) may demonstrate mites

Residents, and especially staff personnel, need support and reassurance that their infections can be treated effectively. Some staff personnel may develop delusions that they continue to have scabies or are reinfected after treatment and return to the work environment. Skin scrapings are imperative to reinforce the absence of mites. In circumstances where skin scrapings are negative in individuals with recent prior treatment and who persistently complain of non-specific pruritus, treatment may be considered for its psychological value. In these instances, crotamiton (Eurax) should be used since it is an effective scabicide and has anti-pruritic qualities.

Occasionally, crusted or "Norwegian" scabies is diagnosed in institutions where heavy crusts containing thousands of mites are observed, particularly on the hands and feet. These patients usually do not exhibit pruritus due to some immunologic abnormality. These patients need intensive care with keratolytic creams to ensure that scabicides penetrate to all mites. Repeat applications of scabicides may be necessary to ensure adequate treatment. These patients shed a large number of mites in the environment. Therefore, prompt and intensive therapy of staff and contacts is the rule. Thorough cleaning of the environment is also indicated including nearby drapes, floors, walls, etc. Laundering and heat drying of clothing and bedding should be sufficient to kill mites in exfoliated scales. The immediate environment should be sprayed with a pyrethrum product for additional protection. Crusted scabies is observed primarily in severely debilitated patients and Down's Syndrome cases.

(Please turn to page 79)

STATE DEPARTMENT/ PUBLIC HEALTH

In other situations, the usual cleaning and laundering procedures are adequate to kill any mites off the host. Generally, mites are transmitted only by close personal contact and not by exposure to fomites — except the infrequent cases of crusted scabies as noted.

Physicians diagnosing scabies in any persons with jobs in institutions or day care centers should notify the administrator to ensure prompt control measures are instituted. It is

always recommended that skin scraping accompany a diagnosis (See Table 1). This is accomplished by placing a drop of mineral oil on the lesion and scraping with a scalpel blade at a right angle until blood appears. Place the oil and skin debris mixture on a slide, spread out, and cover with a cover slip. Examine under low power for mites or eggs. It is best to select a lesion on the webbing of the fingers or flexor surface of a wrist that has not been extensively traumatized by itching. The majority of mites are found at these locations although pruritus frequently occurs at the elbows, axillary fold, beltline, under the breasts, juncture of the thigh and buttock, and medial area of the thighs.

December 1980 Morbidity Report

Disease	Dec. 1980 Total	1980 to Date	1979 to Date	Most Dec. Cases Reported From These Counties
Amebiasis	1	10	78	Baane
Brucellosis	3	9	9	Tama
Chickenpox	999	9525	9130	Palk, Black Hawk, Linn, Johnson
Cytomegalavirus Eaton's Agent infection	2	27	12	Johnson, Pattawattamie
Encephalitis, viral	2	20	43	Lee, Palk
Erythema infectiosum	2	37	77	Dubuque, Jasper
Gastroenteritis (GIV)	13	449	1081	Mitchell
Giardiasis	2986	20537	21075	Linn, Palk, Johnson, Story
Hepatitis, A	9	47	54	Palk
Hepatitis, B	34	214	185	Scatt, Palk
type unspecified	13	105	98	Palk
Herpes Simplex	4	77	67	Scatt
Herpes Zoster	10	117	86	Johnson, Linn
Histoplasmosis	0	3	2	
Infectious mononucleosis	2	28	2	Palk, Scatt
Influenza, lab confirmed	37	379	490	Black Hawk, Palk, Linn
Influenza-like illness (URI)	3	113	34	Clinton, Delaware, Palk
Meningitis aseptic	5622	64985	55952	Pala Alta, Linn, Palk, Johnson
bacterial	9	77	97	Scattered
meningococcal	13	128	119	Palk
Mumps	4	17	15	Palk
	9	64	247	Black Hawk, Des Moines

Disease	Dec. 1980 Total	1980 to Date	1979 to Date	Most Dec. Cases Reported From These Counties
Pertussis	0	2	4	
Rabies in animals	61	529	197	Marshall, Black Hawk Dickinson, Kassuth, Tama
Rheumatic fever	1	1	10	Blackhawk
Rubella (German measles)	1	10	53	Montgomery
Rubeola (measles)	0	20	16	
Salmonella	11	189	188	Scattered
Shigellosis	4	56	84	Scattered
Tuberculosis total ill	4	91	74	Cerro Gordo, Dubuque, Lee
bact. pas.	3	66	61	Dubuque, Lee, Marian
Venereal diseases: Gonorrhea	437	5127	5863	Palk, Black Hawk, Linn, Scatt
Syphilis	3	34	30	Palk

Laboratory Virus Diagnosis Without Specified Clinical Syndrome: Adenovirus — 2, Davis, 1, Johnson; Guillain Barre Synd. — 1, Grundy; Legionnaire's — 1, Cherokee, 1, Marshall; Reye's Syndrome — 1, Dallas; Rheumatic Fever — 1, Black Hawk; Scarlet Fever — 1, Black Hawk, 3, Dallas, 6, Jackson, 1, Marian, 12, Palk, 1, Pawesheik, 1, Webster; Coccidioidomycosis — 1, Dubuque, 1, Linn; Campylobacter — 10, Dubuque, 1, Jefferson, 1, Linn; Toxic Shock — 1, Bremer, 1, Linn, 1, Palk, 1, County Unknown.

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2 — Measles Marshall Co. Week #17
2 — Measles Marshall Co. Week #18
1 — Measles Marshall Co. Week #24

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ABOUT IOWA PHYSICIANS

Dr. John R. Huey, Cedar Rapids, is the new president of the Cedar Rapids-Marion Area Chamber of Commerce. . . . **Dr. Joseph H. Rooney**, Algona, and **Dr. John Barnes**, Missouri Valley, were recent recipients of the Creighton University School of Medicine Silver Anniversary Citation. . . . **Dr. Lowell A. Luhman** has been named medical staff president at Mercy Hospital in Iowa City. Other officers are — **Dr. James Garner**, president-elect; and **Dr. Stephen Wolken**, secretary. All are Iowa City physicians. Dr. Luhmann is a past president of the Johnson County Medical Society. . . . Two Des Moines physicians, **Dr. Udaya M. Kabadi** and **Dr. Kyung-Whan Min**, recently were named Fellows of the American College of Physicians. . . . **Dr. John J. Kavanagh** recently joined the Cogley Clinic in Council Bluffs. Dr. Kavanagh received the M.D. degree at Jefferson Medical College in Philadelphia, Pennsylvania. Following internship and an oncology residency at Medical University of South Carolina, he served a two-year medical oncology research fellowship at M. D. Anderson Hospital and Tumor Institute in Houston, Texas. Dr. Kavanagh is a member of the American College of Physicians. . . . New officers of the medical staff at St. Luke's Methodist Hospital in Cedar Rapids are — **Dr. Kingsley B. Grant**, president; **Dr. Mark J. Tyler**, vice president; and **Dr. Albert R. Coates**, secretary-treasurer. All are CR physicians.

Dr. Lawrence Stratham has been named president of the medical staff at Cedar Rapids' Mercy Hospital; **Dr. John Hess**, vice president; and **Dr. Thomas Schueller**, secretary-treasurer. All are Cedar Rapids physicians. . . . **Joe Tye**, assistant to the director of University of Iowa Hospitals and Clinics, recently was elected president of the American Society of Hospital-Based Emergency Air Medical Services. . . . **Dr. A. J. R. Stueland**, Mason City, retired from

medical practice at the Forest Park Clinic in January. Dr. Stueland received his medical education at the University of South Dakota in Vermillion, and Temple University in Philadelphia, and took postgraduate work at Ancker Hospital in St. Paul, Minnesota. He began family practice in Mason City in 1934. Dr. Stueland plans to continue as medical consultant to Chemical Dependency Services of North Iowa and Good Shepherd Geriatric Center. . . . **Dr. John Ahrens** was named 1981 president of the medical staff at Mercy Hospital in Oelwein; **Dr. Robert Jaggard**, vice president; and **Dr. Steve Cook**, secretary-treasurer. All are Oelwein physicians. . . . **Dr. Carl Vander Kooi**, Orange City, recently returned from a medical mission in Honduras sponsored by the medical group missions program of the Christian Medical Society. . . . The following physicians recently were named officers of the Clinton County Medical Society — **Dr. Robert G. German**, president; **Dr. G. T. Schmunk**, vice president; and **Dr. Preeti Bhatia**, secretary-treasurer.

Hamilton County Medical Society officers for 1981 are — **Dr. Eduardo Reveiz**, president; **Dr. K. Y. Lee**, vice-president; and **Dr. J. X. Latella**, secretary treasurer. All are Webster City physicians. . . . **Dr. Romeo Y. Sembrano** and his wife, **Dr. Elnora Sembrano**, recently began family practice at the Gilfillan Clinic in Bloomfield. Dr. Romeo Sembrano received his medical education at the University of Santo Thomas in Manila, Philippines, Trumbull Memorial Hospital in Warren, Ohio, and Hamot Medical Center in Erie, Pa. He served his family practice residency in Danville, Illinois, and at Monmouth Medical Center in Long Branch, New Jersey. Dr. Elnora Sembrano received her medical education at Far Eastern University in Manila; interned at Brookdale Medical Center in Brooklyn, New York and served her family practice residency at King's County Hospital and Downstate Medical Center in Brooklyn, New York. Both have been in private practice in Keokuk. . . . New officers of the medical staff at St. Joseph's Hospital in New Hampton are — **Dr. Richard Reams**, New Hampton, president; **Dr. Mary Sharon Peraud**, Fredericksburg, vice president; and **Dr. Curtis Rainy**, Elma, secretary-treasurer. . . . **Dr. Robert Johannesen** has opened a family practice in Mason City at the Forest Park office of

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Dr. A. J. R. Stueland, who recently retired. Dr. Johannesen received the M.D. degree at Loyola Medical School in Chicago. He served his family practice residency at the University of Iowa and St. Joseph Mercy Hospital in Mason City.

Dr. L. A. George, Remsen, recently was elected president of the Floyd Valley Hospital medical staff. Other officers are — **Dr. Glenn Van Roekel**, vice president and **Dr. D. K. Faerber**, secretary. Both are LeMars physicians.

DEATHS

Dr. Dwight A. Mater, Sr., 70, retired Knoxville physician, died November 17 at Mercy Hospital Medical Center in Des Moines. Dr. Mater received the M.D. degree at U. of I. College of

Medicine. He was associated with the Mater Clinic and Collins Memorial Hospital for 42 years, retiring in 1978. Dr. Mater was a former member of the Knoxville School Board and the Des Moines Area Community College Board, and past president of the Knoxville Rotary Club. In 1969, he received the Knoxville Community Service Award.

Dr. John P. McCann, 63, Marshalltown, died November 25. Dr. McCann received the M.D. degree at the U. of I. College of Medicine and served his urology residency at University Hospitals. Prior to locating in Marshalltown, he practiced in LaCrosse, Wisconsin.

Dr. David F. Shaw, 78, Britt, died November 24 at his home. Dr. Shaw received the M.D. degree at U. of I. College of Medicine. He began his medical practice in Britt in 1931, retiring in 1971.

Dr. Edwin J. Marble, 73, Marshalltown, died December 28 at Marshalltown Area Community Hospital. Dr. Marble received the M.D. degree at U. of I. College of Medicine; interned and served his residency in urology at Charity Hospital in New Orleans, Louisiana. He began his medical practice in Marshalltown in 1939, retiring in 1977. A veteran of World War II, Dr. Marble was a Diplomate of the American Board of Urology; a past president of the Iowa Urological Society; past president of the Marshall County Medical Society and past president of the medical staff at both Evangelical and Mercy Hospitals. He was also a member of the American Urological Association; North Central Section of the American Urological Association; American Association of Clinical Urologists and the Urological Section of the Pan American Surgical Society.

Dr. John E. Sinning, 75, longtime Marshalltown physician, died January 1 at a Davenport hospital. Dr. Sinning received the M.D. degree at U. of I. College of Medicine and interned in Tacoma, Washington. Dr. Sinning began his medical practice in Marshalltown in 1945. Upon retirement from active practice, Dr. Sinning served on the staff of the Student Health Center at Arizona State University at Tempe. Among the survivors is Dr. John E. Sinning, Jr., a Davenport, Iowa, physician.

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Utilization Review



UTILIZATION REVIEW (UR) is a function that began to mature in the seventies. We've seen it gain pretty much of an established place in today's medical practice glossary. The goal of the UR process is obviously a laudable one — *to assure quality care in the right amounts in the right locations.*

We've turned the 1981 calendar just in time to see UR take a further step. As of January 1, Blue Cross of Iowa required its 96 member hospitals to implement the IFMC Utilization Review program. This means the one million citizens who are Blue Cross of Iowa members henceforth will have any and all of their hospital inpatient admissions subjected to UR. As Iowa physicians know, *the UR function serves to confirm the medical necessity of an admission; it also exists to assure the length of a hospital stay is appropriate for the condition being treated.*

This action by Blue Cross of Iowa is a significant one. But readers should know half of these member hospitals in the 73-county BCI area have already been participating voluntarily in this UR activity. Moreover, as is well known in the medical community, UR has been a required procedure for Medicare/Medicaid patients for several years. With the recent Blue Cross expansion, it's estimated now that 80% of Iowa hospital admissions are under UR scrutiny.

Why has Blue Cross of Iowa (with endorsement from Blue Shield) required this expansion of the UR process?

To followers of medical care delivery, or even those who are alert to the economy generally, the intent is quite apparent. Cost containment! The requirement of UR will give Iowa hospitals a generally standardized system to help them examine why it is several studies show our state near the top in number of people hospitalized and in the number of inpatient days.

Figures cited recently by Blue Cross/Blue Shield are illustrative. In 1979, according to BC/BS reports, Iowa admitted 166 persons under age 65 to hospitals per 1,000 population,

compared with an admission of 115 per M nationally. Additionally, 950 days were spent in Iowa hospitals per 1,000 population, in contrast to a national average of 723. Further chagrin develops when dollars are factored in. For example, a \$32.01 increase in a day's hospitalization occurred in 1980, raising it to an average of \$244.13. The average total 1980 hospitalization stood at \$1,411.65, up from \$1,281.66 in 1979. These findings have helped trigger this expansion of UR.

Again, as most physicians are aware, the performance of UR is under the banner of the Iowa Foundation for Medical Care. This 10-year-old instrument of the medical profession is the entity that creates and administers the UR format. In most instances, however, the actual UR process is carried on by the individual hospital medical staff with support from review coordinators and other ancillary personnel. The UR blueprint applied by the Foundation under the Blue Cross expansion is essentially the same as it has been and is for Medicare/Medicaid beneficiaries.

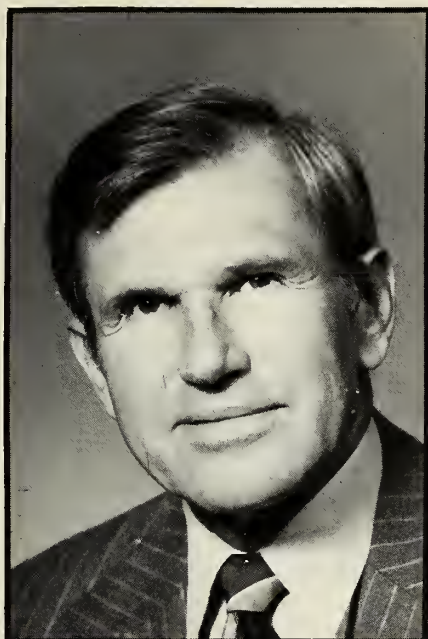
So UR — as it now expands further in the private sector — comes down as a team effort guided by the medical profession. On a routine basis it means that usually 3 to 5 physicians form a hospital UR committee to look at all admissions within their first two days to see if those admissions are medically necessary. Then this committee serves further by applying length of stay criteria while the patients remain in the hospital.

This expansion of UR to cover BCI subscribers will go forward for a year. At that time the program will be assessed as to its impact, its value, its cost, etc. It will be decided then if it's worth continuing in this precise form.

The January 1 expansion represents a greater time commitment for physicians. Schedules are already quite full. Ask a doctor if he likes UR, he'll probably say no. Ask him if it is necessary, he'll probably say yes. It's kind of a dual proposition situation. Most agree the profession needs to assure quality and appropriate utilization. And most would rather see it done by an instrument of the profession — such as the Foundation — and not have an outside agency.

February 1981

Journal of the Iowa Medical Society



PRESIDENT'S PRIVILEGE

BEFORE ME is the 1981 Report of the State Board of Medical Examiners to the Iowa General Assembly. It's a brief statistical analysis of the Board's activity in 1980. It is essentially absent of any accompanying explanation so interpretation is left mostly to the reader.

We know, of course, the Board of Medical Examiners has statutory responsibility for licensing Iowa physicians. The Board must additionally exercise legally-assigned surveillance over those to whom licenses are issued. The work is important and increasingly time-consuming. We need to acknowledge the efforts of those who serve currently and those who have served earlier.

A casual reader of this 1981 BME report would probably conclude we have trouble. The caseload is noted to have increased from 75 complaints in 1978 to 187 complaints in 1979 to 293 in 1980. Indeed, there is reason to be interested and concerned, but there are some mitigating factors.

For example, a new reporting of liability suits to the BME has been required only in the past year or two. This has hiked the complaint volume automatically. Eighty-two complaints came to the BME in 1980 (or 28% of the year's total) from this source.

Other 1980 BME complaint categories showing at least double numbers included: competency (112), drug related (33), ethics and conduct (33) and practicing without a license (13). The cases closed in 1980 totalled 63. Of these closures — the numbers do not balance for reason of duplications — 36 involved BME sanctions and 31 were classed as unfounded.

A carry-over of 142 cases occurred. Such a volume underscores the need for more BME staffing. The IMS has supported this. We back the two additional investigators included in the Governor's budget.

The bottom line — as we say — is good quality care. The medical profession — through the BME and the IMS — must continue this as a basic goal.

William R. Bliss, M.D.

William R. Bliss, M.D.



QUESTIONS - ANSWERS

LYNN D. CARAWAY, M.D.
AMANA, IOWA

1981 HOUSE OF DELEGATES

Dr. Caraway has been speaker of the Iowa Medical Society House of Delegates since 1969. He comments here on the upcoming session of this policy-making body of the state's medical profession. Dr. Caraway is in the private practice of family medicine.

The 1981 session of the Iowa Medical Society House of Delegates will occur May 2-3. Please review the importance of this meeting.

The House of Delegates is the official policy-making body for the state medical society. It represents the "grass roots" involvement of every county medical society. The House acts on resolutions from the county societies, individual delegates, and also on reports from the IMS committees, Board of Trustees, etc. The House receives important informational reports from outside organizations such as the Iowa Foundation for Medical Care, Blue Shield, U. of I. College of Medicine, etc. Actions taken by the interim policy-making body (the Executive Council) are often reaffirmed by the House.

If there are 250 physician delegates who comprise the House and serve as the profession's policymakers, how should they be preparing themselves for this job between now and May?

As soon as they are elected delegates, they should begin to gather the opinions of their colleagues on key issues of the day. They should pursue the possibility of any resolutions and, hopefully, they will have participated in the district caucuses.

You have said the House reference committees are at the heart of the whole process. Why?

The physicians who serve on these committees receive the testimony, weigh the arguments and develop the recommendations. They are chosen by the speaker, vice-speaker and the secretary. We try to select a mix from various specialties and from the rural and urban areas. We try also to pick some experienced delegates and some younger ones.

This is the heart of the democratic process. Debate takes place and views are invited at reference committee hearings. The full House then decides whether to accept, alter or reject the recommendations.

As IMS membership has increased, has there been a corresponding climb in delegate attendance?

NO! Increased attendance in the House has not occurred as it should have. This concerns me and all of the officers. We urge delegates to discharge the responsibility they have accepted to represent their physician constituents.

Can a physician who is not a delegate participate in the House session? Can he/she speak to an issue at a reference committee hearing?

All member physicians are welcome to observe the proceedings of the House. They are urged to attend the reference committee hearings and speak to any of the issues. The seated delegates are the spokespeople on the floor of the House unless special exceptions are made.

What main issues do you think will be before the 1981 House?

Many of the usual issues will appear. Matters relating to economics and the involvement of third parties. The current and future role of paramedical personnel seems a likely topic. It no doubt will be a lively session. I solicit your interest and participation.

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Iowa Foundation for Medical Care Outpatient/Same-Day Surgery List

In late 1980 the Iowa Foundation for Medical Care okayed certain medical and surgical procedures as ones generally suited for performance on an outpatient or same day basis. This list has been promulgated by the Foundation and is provided here for further consideration and reference use by Iowa physicians.

The IFMC outpatient/same-day surgery list was assembled by a Foundation committee of 12 physicians, a doctor of dental surgery and a hospital administrator. Its development included study of similar lists from other states. Its approval by the Foundation board of directors came in November.

Intended use of the list was explained in Foundation material sent earlier to Iowa physicians and hospitals. Initial utilization by Iowa hospitals has been requested during the first quarter of 1981. In the second quarter, the IFMC expects to begin evaluating use of the list to see what impact there has been on the incidence of short stays.

The quality of care is not to be compromised by use of the list. Its application is to routine, primary and independent procedures. Where a specific need is identified hospitalization should occur.

Use of the phrase *same day* in the program designation is to accommodate any smaller hospital that lacks specific outpatient surgical facilities. The *same day* reference means such hospitals should use existing surgical suites and recuperative beds. The intent is to assure the patient is in and out of the hospital within 24 hours to avoid an "admission."

The Foundation will keep the outpatient/same-day surgery list under ongoing evaluation and will modify it as desirable. Its scrutiny will be part of a total 1981 effort by IFMC physician committees to study medical admissions.

In its efforts to encourage greater use of less expensive outpatient services, the Foundation stresses expanded coverage in its contacts with insurance companies and business/industry.

OTOLARYNGOLOGY/AUDITORY SYSTEM

21310 — Treatment of closed or open nasal fracture without manipulation

69420 — Myringotomy including aspiration and/or eustachian tube inflation

69433 — Tympanostomy (requiring insertion of ventilating tube), local or topical anesthesia; unilateral

69434 — Tympanostomy (requiring insertion of ventilating tube), local or topical anesthesia; bilateral

69436 — Tympanostomy (requiring insertion of ventilating tube), general anesthesia; unilateral

This list includes surgeries that should usually be performed on an outpatient basis when they are performed as a routine, primary, independent procedure. (Codes are generally adapted from CPT-4 system.)

69437 — Tympanostomy (requiring insertion of ventilating tube), general anesthesia; bilateral

GENERAL SURGERY/INTEGUMENTARY SYSTEM

11100 — Biopsy of skin, subcutaneous tissue and/or mucous membrane (including simple closure), unless otherwise listed (separate procedure); one lesion

11101 — Biopsy of skin, each additional lesion

11750 — Excision of nail and nail matrix, partial or complete (eg, ingrown or deformed nail), for permanent removal

12000 — Repair of superficial wounds

Series

19100 — Biopsy of breast; needle (separate procedure)

19101 — Biopsy of breast; incisional

GENERAL SURGERY/DIGESTIVE SYSTEM

- 43235 — Esophagogastroduodenoscopy, diagnostic
- 43251 — Esophagogastroduodenoscopy; with removal of polyp(s)
- 45300 — Proctosigmoidoscopy; diagnostic (separate procedure)
- 45310 — Proctosigmoidoscopy; with removal of polyp or papilloma
- 45330 — Sigmoidoscopy, flexible fiberoptic; diagnostic
- 45333 — Sigmoidoscopy, flexible fiberoptic; with removal of polyp(s)
- Many Codes — Surgical removal of impacted teeth
- 49500 — Repair inguinal hernia, under age 5 years, with or without hydrocelectomy; unilateral
- 49501 — Repair inguinal hernia, under age 5 years, with or without hydrocelectomy; bilateral

GYNECOLOGY/FEMALE GENITAL SYSTEM

- 57500 — Biopsy, single or multiple, or local excision of lesion, with or without fulguration (separate procedure)
- 57520 — Biopsy of cervix, with or without D&C
- 58120 — Dilation and curettage, diagnostic and/or therapeutic
- 59840 — Legal (therapeutic) abortion, completed with D&C and/or vacuum extraction
- 59880 — Laparoscopy for visualization of pelvic viscera
- 59882 — Laparoscopy for visualization of pelvic viscera; with fulguration of oviducts

NEUROSURGERY/NERVOUS SYSTEM

- 28043 — Excision, benign tumor; subcutaneous
- 64721 — Neurolysis and/or transposition; median nerve at carpal tunnel

ORTHOPEDICS/MUSCULOSKELETAL SYSTEM

- 11750 — Excision of nail and nail matrix, partial or complete (eg, ingrown or deformed nail) for permanent removal
- 11760 — Reconstruction of nail bed; simple
- 11762 — Reconstruction of nail bed; complicated
- 25111 — Excision of ganglion, wrist (dorsal or volar); primary
- 26055 — Tendon sheath incision for trigger finger
- 26060 — Tenotomy, subcutaneous, single, each digit
- 26075 — Arthrotomy with exploration, drainage or removal of loose or foreign body; metacarpophalangeal joint
- 26080 — Arthrotomy with exploration, drainage or removal of loose or foreign body; interphalangeal joint
- 26160 — Excision of lesion of tendon sheath or capsule (eg, cyst or ganglion)
- 26455 — Tenotomy, flexor, single, finger, open, each
- 27373 — Arthroscopy, knee, diagnostic (separate procedure)
- 27376 — Arthroscopy, knee, surgical, with synovial biopsy
- 27377 — Arthroscopy, knee, surgical, with removal of loose body
- 28080 — Excision of Morton neuroma, single
- 28234 — Tenotomy, open, extensor, foot or toe

28285 — Hammertoe operation; one toe (eg, interphalangeal fusion, filleting, phalangectomy)

28290 — Hallux valgus (bunion) correction, with or without sesamoidectomy; simple exostectomy (Silver type procedure)

Many Codes — Fractures (Colles' type, upper extremities, toes, fingers, clavicular fractures, lower extremities, ankle or foot bones, fibula)

UROLOGY/URINARY SYSTEM

- 52100 — Cystourethroscopy
- 52280 — Cystourethroscopy, with calibration and/or dilation of urethral stricture or stenosis, with or without meatotomy and injection procedure for cystography, male or female; hospital
- 53021 — Meatotomy, cutting of meatus (separate procedure), except infant
- 53025 — Meatotomy, cutting of meatus (separate procedure), infant
- 53600 — Dilation of urethral stricture by passage of sound, male; initial
- 53601 — Dilation of urethral stricture by passage of sound, male; subsequent
- 53620 — Dilation of urethral stricture by passage of filiform and follower, male; initial
- 53621 — Dilation of urethral stricture by passage of filiform and follower, male, subsequent
- 53660 — Dilation of female urethra including suppository and/or instillation; initial
- 53661 — Dilation of female urethra including suppository and/or instillation; subsequent
- 55250 — Vasectomy, unilateral or bilateral (separate procedure) including postoperative semen examination(s)

ENDOSCOPY

- 31620 — Bronchoscopy; diagnostic, rigid bronchoscope
- 31621 — Bronchoscopy; diagnostic, fiberoptic bronchoscope (flexible)
- 31625 — Bronchoscopy; with biopsy, rigid bronchoscope
- 31626 — Bronchoscopy; with biopsy, fiberoptic bronchoscope (flexible)
- 45300-45319 — Proctosigmoidoscopy; diagnostic (separate procedure) and minor operative procedures
- 45330-45334 — Sigmoidoscopy, flexible fiberoptic; diagnostic and minor operative procedures
- 45360-45371 — Colonoscopy, fiberoptic, beyond 25 cm to splenic flexure; diagnostic procedure and minor operative procedures
- 45378-45386 — Colonoscopy, fiberoptic, beyond splenic flexure; diagnostic procedure, and minor operative procedures

RESPIRATORY SYSTEM

- 30115 — Excision, nasal polyp(s); extensive, unilateral
- 30116 — Excision nasal polyp(s); extensive, bilateral
- 31620 — Bronchoscopy; diagnostic, rigid bronchoscope
- 31621 — Bronchoscopy; diagnostic, fiberoptic bronchoscope (flexible)
- 31625 — Bronchoscopy; with biopsy, rigid bronchoscope
- 31626 — Bronchoscopy; with biopsy, fiberoptic bronchoscope (flexible)

THINGS YOU SHOULD KNOW

NOMINATING COMMITTEE

Representatives from the 13 IMS councilor districts will participate Sunday, April 12, in a meeting of the Society's 1981 Nominating Committee. Any candidates for 1981-82 offices should be made known to your district rep prior to the April 12 meeting. A slate of nominees will go to the House of Delegates on May 2/3.

HANDBOOK DISTRIBUTION

Delegates, alternates and other participants in the 1981 IMS House of Delegates will be receiving their handbooks in late March. The handbook contains committee, council and board reports, plus any resolutions in hand at that time.

RESOLUTIONS

How do you establish IMS policy? One key way is to introduce a resolution. Resolutions may be introduced on any medical topic by a county medical society, an individual delegate or by a councilor district. The earlier they are submitted the better.

CHIROPRACTIC

A Chicago federal jury decided January 30 that medicine has not conspired to eliminate chiropractic. The verdict covered a suit involving several medical defendants, including the AMA. Iowa interest in the outcome is great due to legal action now being pursued by the Health Equalization Committee of the Iowa Chiropractic Society against the AMA, IMS and other defendants. Appeals of the Iowa case have been declined and it is proceeding in its original jurisdiction.

PA REVIEW

Reinforcement was given at a February meeting of the IMS Committee on Delivery of Health Services to the need for adequate supervision of physician's assistants by their sponsors. Supervising physicians at the meeting praised the help coming from their PAs. An update was received on the U. of I. PA training program.

CME REPORTING

Iowa physicians will soon have their second go-around of required continuing education reporting. The State Board of Medical Examiners expects to send its license renewal applications shortly. With them will go the CME reporting form. The IMS has assisted in recent efforts to condense and simplify the first-year form.

'81 SCIENTIFIC SESSION

Kansas City's Alameda Plaza is the site of the 1981 IMS Scientific Session June 24 to 26. The first-day program will deal with marital matters and will interest both physicians and spouses. 11 hours of Category I credit will be available; credit toward FP certification has been requested. A February letter was sent to member physicians about the '81 Scientific Session.

MEMBERSHIP SURVEY

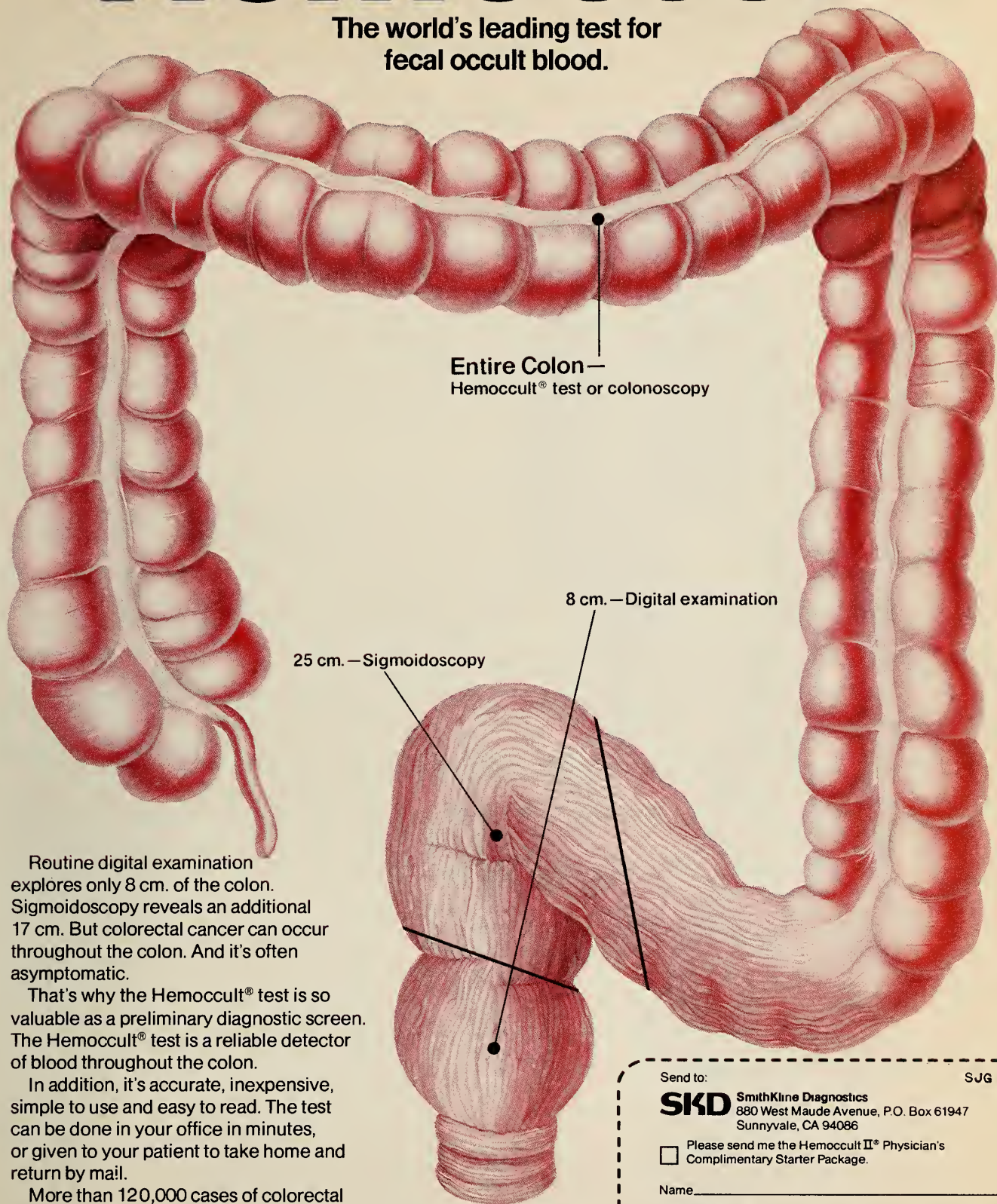
Just at 1,100 IMS membership surveys were in hand at March JOURNAL presstime. The response has exceeded 34% of the number sent. The perceptions of Iowa physicians on key medical topics will be compiled from the survey for presentation to the House of Delegates.

FOUNDATION MEETS

At its March 25 annual meeting the Iowa Medical Society Foundation (Scanlon Foundation) board of directors will review the medical student loan program in depth. \$69,594 was loaned to Iowans in the 1980-81 academic year.

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VOX DOCS

Please take a look at this month's Vox Docs question. It's below! Give us your answer. Send it to IMS JOURNAL, 1001 Grand Avenue, West Des Moines, Iowa 50265. Last month's question and answer results are shown to the right with several of the comments we received printed below.

"The few hours required, while not sufficient to give excellence, assure at least minimal contact with new ideas and information." — *Don N. Orelup, M.D., Albia*

"I would suggest this be a requirement only for those physicians not already maintaining a CME record for their specialty." — *Larry W. Goetz, M.D., Creston*

"Conscientious physicians do continue their education, but there are those that are overworked or under-motivated (lazy?) and this nudges them." — *M. A. Arends, M.D., Manchester*

"Certainly, the idea of requiring study is important; however, on the other hand, much of the continuing education is worthless and a rip-off." — *Carlyle C. Moore, M.D., Emmetsburg*

LAST MONTH'S QUESTION

Is requiring continuing education for Iowa medical relicensure a good thing?

YES 66%

NO 24%

DON'T KNOW 10%

"It is no guarantee of quality medical care. The overall interest in CME throughout the state has increased, especially with those physicians who otherwise would not participate. The quality and availability of CME locally has increased as a direct result. For the average physician, mandatory CME reporting is a nuisance." — *Thomas L. Pester, M.D., Council Bluffs*

"Yes, there is, however, great potential for the 'rip-off.' I think home study courses, such as those offered by the American Urological Association, provide greater benefit than expensive meetings." — *Paul L. Rohlf, M.D., Davenport*

MARCH QUESTION FOR IOWA PHYSICIANS

Elsewhere in this issue of the IMS JOURNAL is a listing of procedures suggested for outpatient/same-day surgery. How do you feel about the current emphasis on performing more surgical procedures on this basis?

☐ THINK IT'S A GOOD IDEA

☐ THINK IT'S A BAD IDEA

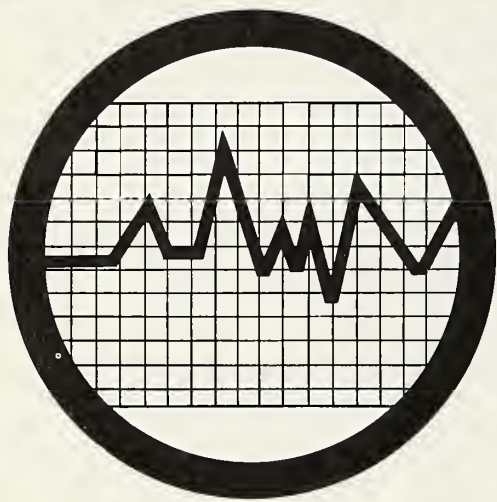
☐ NO STRONG OPINION

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Fractures of the Scaphoid: Important But Easily Missed Injuries

PETER LEPSE, M.D. and

JOSEPH A. BUCKWALTER, M.D.

Iowa City, Iowa

OF ALL FRACTURES of the wrist, scaphoid fractures rank second in frequency only to Colles' fractures.¹⁰ Despite their frequency, the diagnosis is easily missed because the physical findings usually are not diagnostic and the fracture may not be apparent on initial roentgenograms. Missing the diagnosis may delay treatment until the patient returns with pain and stiffness of the wrist secondary to non-union or necrosis of the scaphoid. Fresh fractures identified early and treated appropriately will unite in at least 90% of cases,³ but the potentially disabling problems of non-union and avascular necrosis may develop if the initial diagnosis is inaccurate or the treatment inadequate.

Dr. Buckwalter is an assistant professor at the Department of Orthopaedic Surgery at the University of Iowa College of Medicine. Dr. Lepse was a senior medical student when this paper was prepared and is now a resident in orthopaedics at the University of Arkansas.

Conventional treatment promotes healing in more than 90% of scaphoid fractures. Even so, non-union continues to be a disproportionate problem. This stems from either slow contact by the injured or because the fracture was not suspected by the physician. The manner of treating and diagnosing is summarized here.

This paper reviews the anatomy and blood supply of the scaphoid and the diagnosis, classification and treatment of scaphoid fractures.

ANATOMY AND BLOOD SUPPLY

The scaphoid, a curved bone, links the proximal and distal carpal rows. Its 4 surfaces articulate with 5 bones (Figure 1).³ The proximal convex surface articulates with the radius. The concave ulnar surface, combined with the lunate, forms a cup for articulation with the capitate. The proximal pole of the bone has a small surface that articulates with the lunate. Distally, the scaphoid presents a biarticular surface for articulation with the trapezium and trapezoid (greater and lesser multangulars). These surfaces are separated by a helical,

(Please turn to page 102)

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AS THE HENRY ALBERT SCIENTIFIC PRESENTATION FOR THE MONTH OF MARCH 1981.

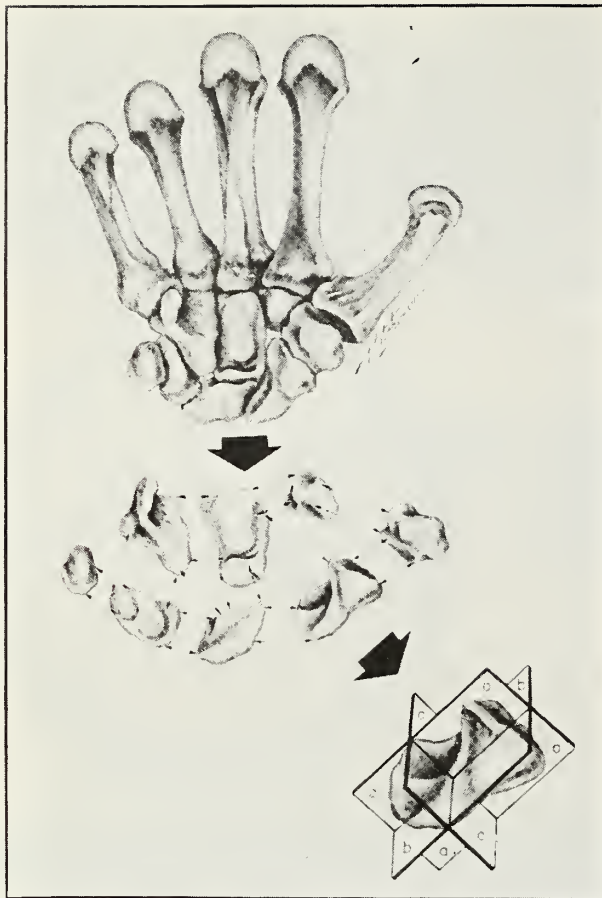


Figure 1. Diagram of the carpal bones showing the articulations of the scaphoid. (Reprinted with permission from the Journal of Bone and Joint Surgery, 48A:1128, 1966.)



Figure 2. Diagram showing the blood supply of the scaphoid. The three vessels penetrating the bone originate from the radial artery. Lv = lateral volar vessels, Da = dorsal vessels, Di = distal vessels. (Reprinted with permission from the Journal of Bone and Joint Surgery, 48A:1136, 1966.)

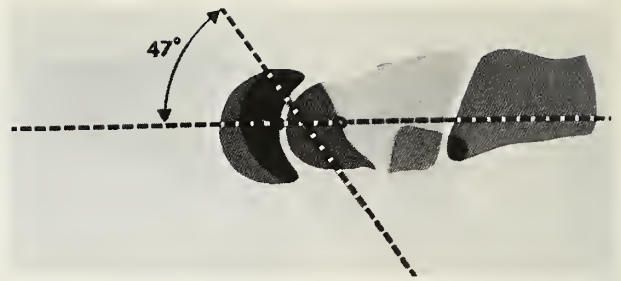


Figure 3. Diagram showing the lateral view of the wrist. Note that the radius, lunate, capitate and third metacarpal fall on a straight line and that the axis of the scaphoid lies at a 47° angle to this line. (Reprinted with permission from the Journal of Bone and Joint Surgery, 54A:1614, 1972.)

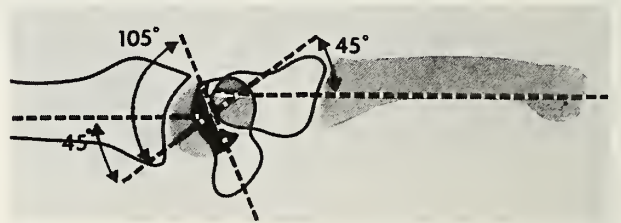


Figure 4. Diagram showing the lateral view of a wrist with the dorsiflexion instability pattern. The axis of the scaphoid lies at a 105° angle to the line through the lunate. (Reprinted with permission from the Journal of Bone and Joint Surgery, 54A:1615, 1972.)

roughened area starting on the dorsum of the bone and winding around to the tubercle. Here the dorsal radiocarpal and radial collateral ligaments insert, and branches from the radial artery enter at these sites to supply the bone.¹⁰ The waist of the scaphoid is the central indented part without ligamentous attachments.³

The blood supply of the scaphoid explains differences in healing time for fractures of different parts of the bone¹² and leads to necrosis of the proximal pole following a fracture. Three groups of vessels originating from the radial artery and/or its superficial palmar branch (Figure 2) penetrate the bone at the level of the waist and the distal tubercle. The laterovolar group of vessels (Lv) constitute the most proximal, largest, and apparently the most important system: they enter the bone in a triangular area on the volar surface just proximal to the tuberosity and on the adjacent lateral surface as well. The dorsal group of vessels (Do) originate from the radial artery just distal to the superficial palmar artery and penetrate along the insertion of the dorsal radiocarpal

ligament. The third group of vessels, the distal branches (Di), follow the lateral radiocarpal ligament and insert on the tuberosity of the scaphoid as well as on the trapezium. Intraosseously, the laterovolar and dorsal groups anastomose and deliver blood supply to the proximal two-thirds of the bone via a system of arcades, with the major contribution being delivered by the laterovolar group. The distal group remains confined to the tuberosity. Hence, any fracture of the bone at or proximal to the level of the waist endangers this system of intraosseous anastomoses, threatening the blood supply to the more proximal part of the bone.

DIAGNOSIS

The classic history of patients with scaphoid fractures includes a fall on the outstretched hand forcing dorsiflexion of the wrist. The scaphoid links the proximal and distal carpal rows, and thereby helps block excessive dorsiflexion. When the wrist is forced into 95° to 100° of dorsiflexion, bending loads applied over the distal pole of the scaphoid fracture the bone at its waist.¹³ Following fracture of the scaphoid, movement of the wrist becomes painful, and physical examination usually reveals localized tenderness over the scaphoid. Swelling and palpable displacement of the fracture fragments rarely occur; thus, definite clinical diagnosis can be difficult.

Consequently, the radiological exam is crucial in evaluating scaphoid injuries. At least AP and lateral views with the wrist in neutral position and oblique views with the wrist in ulnar deviation should be obtained.¹⁰ Some recommend a full "motion study" of the wrist, i.e., AP and lateral views in neutral position, maximal radial deviation and maximal ulnar deviation.³ While the AP or oblique views usually show the fracture line best, the lateral view provides valuable information regarding angular relationships of the carpal bones. With the wrist in neutral position, the lateral view shows that the longitudinal axis of the distal radius, lunate, capitate and third metacarpal fall on a line (Figure 3).⁵ The longitudinal axis of the scaphoid falls at an angle averaging 47° to this line (normal range 30-60°). In hyperdorsiflexion injuries, ligamentous disruption may occur, as well as a fracture, and the lunate will

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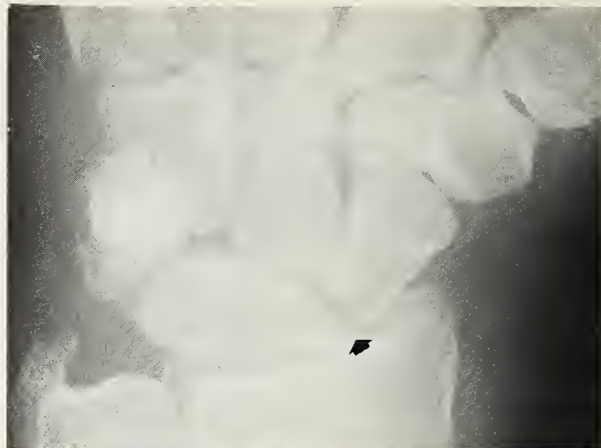


Figure 5. Radiograph showing a fracture through the proximal third of the scaphoid.

tilt such that its distal surface points dorsalward creating a dorsiflexion instability pattern (Figure 4). A scapholunate angle greater than 70° indicates dorsiflexion instability, with the lunate dorsiflexed due to loss of the connecting rod function of the scaphoid. Presence of this pattern may change management of the fracture as discussed below.

Frequently, the fracture will not be visible on the initial film; therefore, all patients with an appropriate history and "snuffbox" tenderness should be treated as if a fracture were present until x-rays demonstrating the absence of a fracture are obtained 2 to 4 weeks later.

CLASSIFICATION

Two classification systems help in understanding the prognosis and treatment of scaphoid fractures: a system based on the location of the fracture and a system based on the displacement of the fracture and dorsiflexion instability of the wrist.

Location of the fracture: Scaphoid fractures are most frequently classified according to their location: 1) proximal one-third (Figure 5), 2) waist (Figure 6) and 3) distal one-third (Figure 7). Some authors separate fractures of the distal tuberosity into a fourth group. As might be expected from the blood supply, distal fractures heal faster, with an average healing time as short as 4 weeks for the tuberosity fracture in contrast to as long as 20 weeks for a fracture of the proximal pole.³ A further distinction is made between oblique fractures and transverse fractures, with the transverse type healing better. This may be due to shearing forces

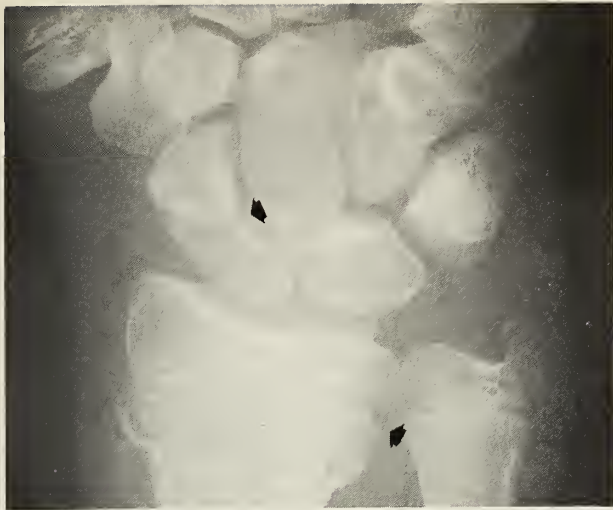


Figure 6. Radiograph showing a non-displaced fracture through the waist of the scaphoid and a distal radius fracture. The scaphoid fracture was missed in this child.

being imparted to the fragments by motion of the first and second digits in the oblique type.⁸ The waist fracture is by far the most common, occurring in about 70% of cases, with distal one-third fractures in about 10% and proximal one-third fractures in about 20%.⁸

Displacement and dorsiflexion instability: Weber has proposed a different classification based on the presence of the dorsiflexion instability pattern and on the presence of displacement.¹⁴ He has delineated three categories of fracture: 1) non-displaced (Figure 6), 2) angulated (Figure 8) and 3) displaced (Figure 7). In the non-displaced fracture the ligaments are not disrupted, and roentgenograms reveal only minimal opening of the fracture line (less than 1 mm) or none at all. In contrast, when the scaphoid fractures and the ligaments on either the dorsal or palmar ridge in the area of the waist are disrupted, the fracture will angulate. This angulation appears as abnormal rotation of the lunate and is usually represented by the dorsiflexion instability pattern with the lunate dorsiflexed (Figures 4 and 8). Displacement of the fracture occurs if ligaments are torn from both the dorsal and palmar ridges of the scaphoid, and is represented by a step off of greater than 1 mm between the fragments on the capitate surface. As with the anatomic classification, the prognostic relevance of this schema is related to vascular supply. In the non-displaced fracture, soft tissue connections and the accompanying vascular supply remain intact. In the angulated fracture, one of the

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Figure 7. Radiograph showing a significantly displaced fracture through the distal third of the scaphoid. This patient went on to non-union and eventually required bone grafting.

periosteal surfaces of the waist is intact and the blood supply to the proximal fragment is preserved. However, this fracture may heal with persistent dorsiflexion instability and give rise to persistent symptoms. Finally, in the displaced variety, both dorsal and volar periosteal surfaces of the waist have been disrupted and the vascular supply of the proximal fragment is frequently destroyed, raising the possibility of avascular necrosis of the proximal pole. Consequently, Weber regards displaced fractures (those having greater than 1 mm step off on the capitate surface) as injuries demanding open reduction and internal fixation in order to achieve the best result. Through analysis of the forces which produce scaphoid fractures in the laboratory, he has determined that at the times of fracture the radial palmar ligaments are lax.¹³ Therefore, he recommends immobilization of nondisplaced fractures in neutral flexion and slight radial deviation of the wrist so that the ligaments do not distract the fragments. In the case of the angulated fracture, alignment of the fragments is best achieved by placing the wrist in maximal radial deviation and neutral flexion, and this is the recommended position of immobilization.

TREATMENT

Many types of casts have been used to immobilize scaphoid fractures. Bohler recommended a short-arm plaster cast from the prox-

imal forearm to the mid-palmar crease with the proximal phalanx of the thumb included. Others have extended the cast above the elbow to inhibit supination and pronation and prefer to extend the cast to include all the digits to just past the tips.³ The superiority of long-arm casts over short-arm casts is called into question by a Finnish prospective study of 100 scaphoid fractures randomly treated with either short or long-arm casts, both extending to the mid-palmar crease and to the interphalangeal joint of the thumb.¹ In this study, 92% of the fractures united within 7 weeks and no difference was found between the 2 groups. While the indications for operative treatment are somewhat controversial, most authors agree that operative intervention should be considered only if there is significant displacement of the fragments.³ In immobilizing the wrist, slight radial deviation and neutral or slight palmar flexion appears to be the most logical position,¹³ with the hand being placed in a grasp position as if it were holding a tennis ball (Figure 9). In Weber's angulated type of fracture, maximum radial deviation and neutral flexion is recommended.

After the initial casting, follow-up x-rays may be obtained at 2 to 4 weeks to rule out fracture if none was visible on the initial film; otherwise, the patient usually returns in 6 weeks. Some have recommended checking the casts more frequently for snugness, e.g., weekly,² to maintain more rigid immobilization. At the 6 week return visit, clinical and roentgenographic checks determine if the wrist should stay in plaster or whether a thumb spica splint can be used.³ Persistent snuffbox tenderness or lack of radiological union indicate the need for continued immobilization. The second return visit is usually scheduled 4 to 6 weeks later, when x-rays should be obtained again. Most fractures need no further immobilization by this time, but re-injury is common and protective support is usually recommended for at least an additional month, e.g., with a leather lacer. While the great majority of delayed unions will go on to osseous union with extended immobilization,¹⁰ economic or other considerations may intervene and opinion is divided on whether these patients should be treated by open reduction and internal fixation^{6, 7} or prolonged cast immobilization.

Discussion of the surgical repair of non-union of the scaphoid is beyond the scope of this review. However, operative intervention based on roentgenographic diagnosis is not indicated.¹⁰ Patients with established non-union may be asymptomatic and should be observed until disabling symptoms occur. Several methods of treatment ranging from prolonged immobilization to internal fixation with bone grafting have been advocated, all with high rates of success in appropriate cases.^{6, 9, 10} Analysis of patients eventually requiring surgery for non-union reveals the great majority of such cases are due to lack of initial treatment for their injury because they did not seek medical attention or because the physician's index of suspicion for the injury was not sufficiently high.¹⁰ Non-unions due to inadequate therapy or in spite of appropriate initial therapy are much less common, though still significant, accounting for 13% and 20% of cases, respectively, in one series.¹⁰ Physicians should be suspicious of possible scaphoid fractures in patients with other injuries to the forearm and wrist as these are often more painful and divert attention away from the scaphoid (Figure 6).

SUMMARY

1. More than 90% of scaphoid fractures treated with conventional methods will heal, yet non-union continues to be a disproportionate problem. Non-union most commonly results from lack of initial treatment either because the patient did not consult a physician or because the fracture was not suspected or diagnosed by the physician.

2. The common mechanism of scaphoid fracture is forced dorsiflexion of the wrist occurring during a fall on the outstretched hand. The only consistent physical finding is that of snuffbox tenderness.

3. The minimum radiological examination of the wrist should include an AP and lateral of the wrist in neutral position and oblique views with the wrist in ulnar deviation.

4. Any patient with an appropriate history of snuffbox tenderness should be treated as if a fracture were present, even if none is visible on the initial films, and treatment should be continued until x-rays show no fracture present at 2 to 4 weeks.

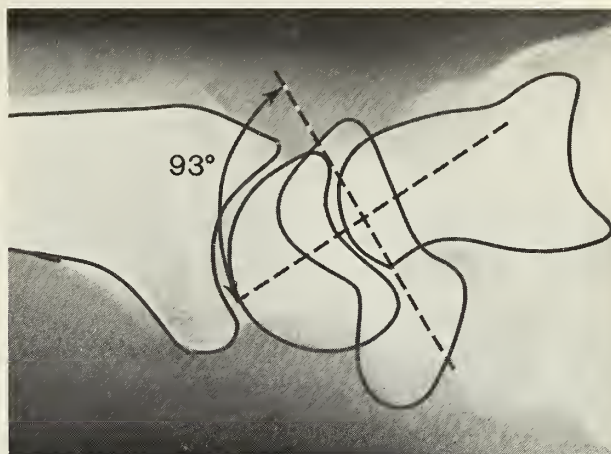


Figure 8. Radiograph showing the dorsiflexion instability pattern following a scaphoid fracture. The fracture of the scaphoid is not apparent in this lateral view but the 93° angle between the scaphoid and lunate is abnormal indicating instability.



Figure 9. Photographs showing a hand immobilized in slight radial deviation and neutral flexion with a short-arm cast extending to the mid-polar crease and the interphalangeal joint of the thumb.

5. Healing time is increased markedly in oblique fractures and those of the proximal one-third.

6. Open reduction and internal fixation is considered only in those with significant displacement. The preferred position of immobilization is in slight radial deviation and neutral flexion, or in marked radial deviation for those fractures with evidence of ligamentous disruption.

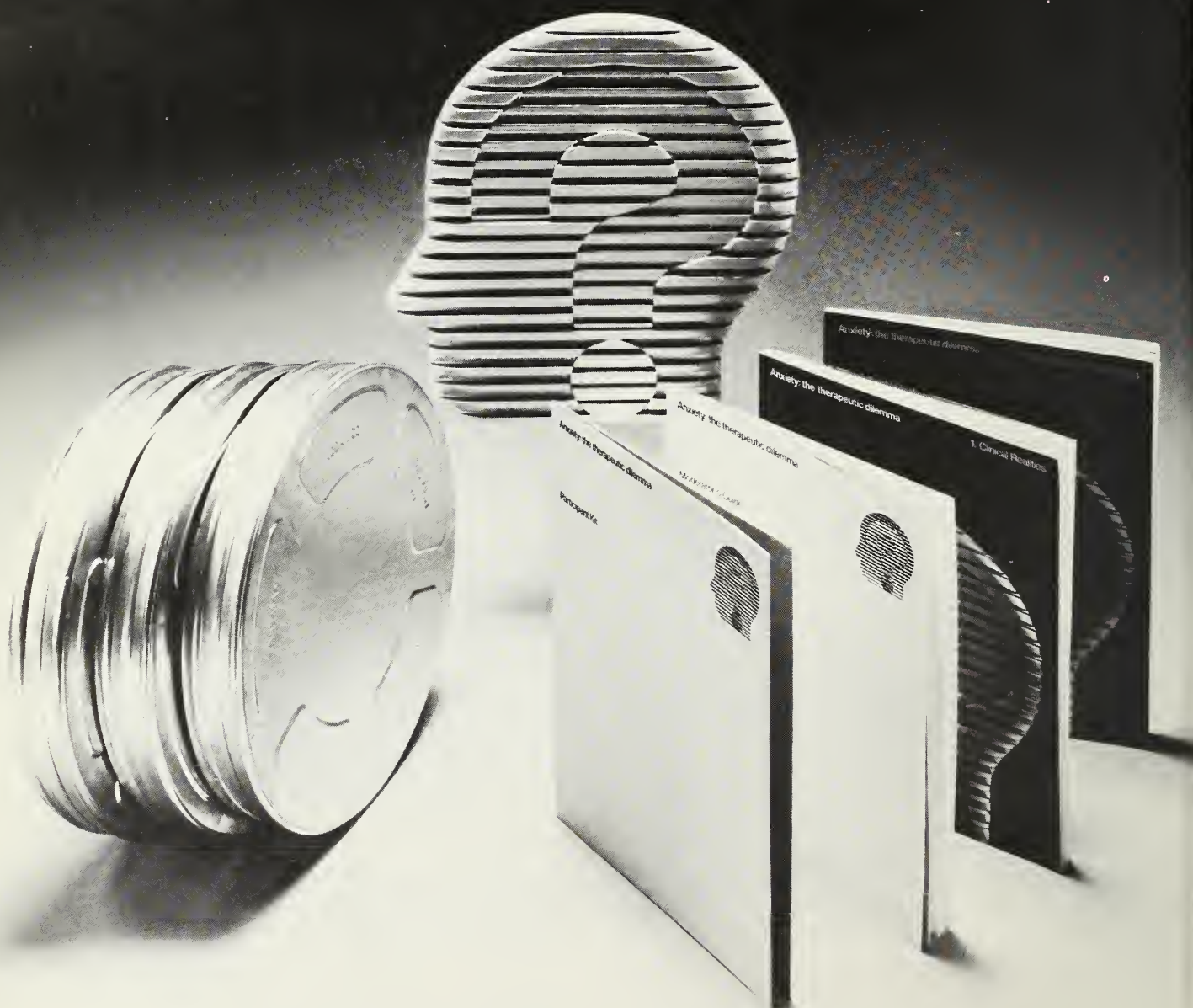
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COMMENTING EDITORIALY

MARION E. ALBERTS, M.D.
SCIENTIFIC EDITOR

DECISION-MAKING VS PERFORMANCE

ETHICAL TENSIONS and professional jealousy often become entangled in deciding the worth of a physician's services. I recall a related incident early in my medical career. I was asked by a family why I submitted a bill for services when their infant child was hospitalized.

I had admitted the infant to evaluate an etiology of projectile vomiting. The history, examination and the x-ray study by the radiologist confirmed a diagnosis of hypertrophic pyloric stenosis. The studies and the diagnostic conclusions were completed easily and quickly. The surgeon was summoned to provide his services. The child had an uneventful post-operative course. Feedings were resumed early in the postoperative period with no further vomiting. The infant was cured.

After the child was released from the hospital the bills were presented. The family called to ask why I should make a charge. After all, the surgeon did the work and corrected the problem. In the eyes of the parents, my involvement and decisions were unimportant compared to the surgical service; this they believed represented the full solution to the malady. Some discussion cleared the air, but there was, I am sure, a lingering feeling of animosity with these good people.

Almy, Thomas P.: The role of primary physicians in health care "industry." *New Engl. J. Med.*, 304:225, 1981.

Has the use of new instrumentation and diagnostic acumen changed the understanding of the public as to the worth of medical care? If reimbursement policies and incentives to itemize professional statements continue as they have in recent years, physicians are more likely to reach desired income levels by increased use of expensive technology. To escape massive technologic entrapment we need to stress the importance and value of basic diagnostic skills — and talking with patients about them. Physicians ought to spend ample time learning the needs of their patients and sharing with them and their relatives the decisions being made. Third parties must recognize the value of such discourse.

A good discussion of this subject is presented by Thomas P. Almy in the January 22, 1981 issue of the *NEW ENGLAND JOURNAL OF MEDICINE*. It is reported our use of technologic procedures far exceed those in other countries. It is time for all to re-examine our way of doing things to assure the patient receives satisfaction as well as value for his health dollar. — M.E.A.

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STAGE V FOR PHYSICIANS

Dear Editor:

Dr. Caplan's January column (*Our Man on Education*) was significant. He describes research of Dr. Lawrence Kohlberg of Harvard. This meritorious research centers on a theory of 7 stages of moral development.

Stage 0 is the pre-moral stage. It is the animal and newborn infant stage. Animals remain Stage 0 while humans move to higher ranks with varying success. As members of an animal species all persons are "created equal," but in terms of moral development no two persons are equal.

Kohlberg's Stage I is characterized as total selfishness. It embodies violent behavior and produces warfare. Most humans outgrow this stage by age 3.

Stage II is hedonism, the new morality, the sex revolution, *Playboy* magazine and abortion. Most children pass this by age 5.

Stage III is commonly called the Charlie Brown stage. It is the goody-goody time. It covers those from age 7 to 10 and encompasses children's literature, Walt Disney and TV.

Stage IV is concerned with law and order. It is the highest stage the general population achieves. It involves business, finance, politics and everyday living. It begins to emerge during adolescence.

Stage V represents professional persons and college graduates. It recognizes a morality above the written law. It is personified by the liberal arts college education.

Stage VI is the ultimate of human existence. Everyone has his own list of Stage VI individuals. It is achieved by very few, some say by 10% of the population.

"Good moral character" was an important

criterion when I applied for medical school (1951). This is covered in Kohlberg's Stage V. The research cited by Caplan suggests the medical profession has been successful in attracting persons with good morality. Close to 99% of the subjects studied (pediatric residents) appeared to be in Stage V.

Kohlberg's work seems to have produced an objective tool for medical school admissions committees to use in measuring moral status. A problem is that Stage V is rarely achieved before age 25, a time somewhat beyond normal medical school entry.

In his consideration, Kohlberg says an individual will always perform at the highest level he has achieved. A Stage V will function at this level even though he is capable of any lesser activity. For example, a Stage V can be drafted into the army and asked to fight in a Stage I war. Communications become a problem between individuals at either lower or different levels. For example, a lawyer must converse with a judge at Stage V, with the jury at Stage IV, and with his client at Stage I. A physician must provide professional service at Stage V, but he needs to communicate at times with Stage I and II patients, e.g., the 3-year old at Stage I; the 5-year old at Stage II, and the 8-year old at Stage III. The parent also must deal with this and resist demanding Stage IV conduct from a Stage II or III child.

Medical school admissions committees should see their graduates achieve Stage V. However, they should recognize that as applicants they are in either Stages II, IV or V. Applicants at Stage IV will probably achieve Stage V. Applicants at Stage II should be rejected. Here are 4 Stage II identifying factors: (1) cheating in college; (2) adversary attitude toward faculty, (3) sexual immorality, and (4) preoccupation with the wealth to be achieved in this profession. — C. E. Berryhill, M.D., *Readlyn*

JIMSON WEED

Dear Editor:

I intended to report this case years ago. In September, 1957, the mother of a 5-year-old boy brought the child in with nausea, vomiting and greatly dilated pupils. I had my brother, Arthur, an eye, ear, nose and throat specialist,

take a look at him because of the dilated pupils. We agreed the child had atropine poisoning.

We questioned the mother and she stated no one in the family had been taking medicine.

The child had on blue jeans and we found Jimson weed seeds in his pockets. He recovered without any special treatment. — F. R. Richmond, M.D., *Burlington, Iowa*.

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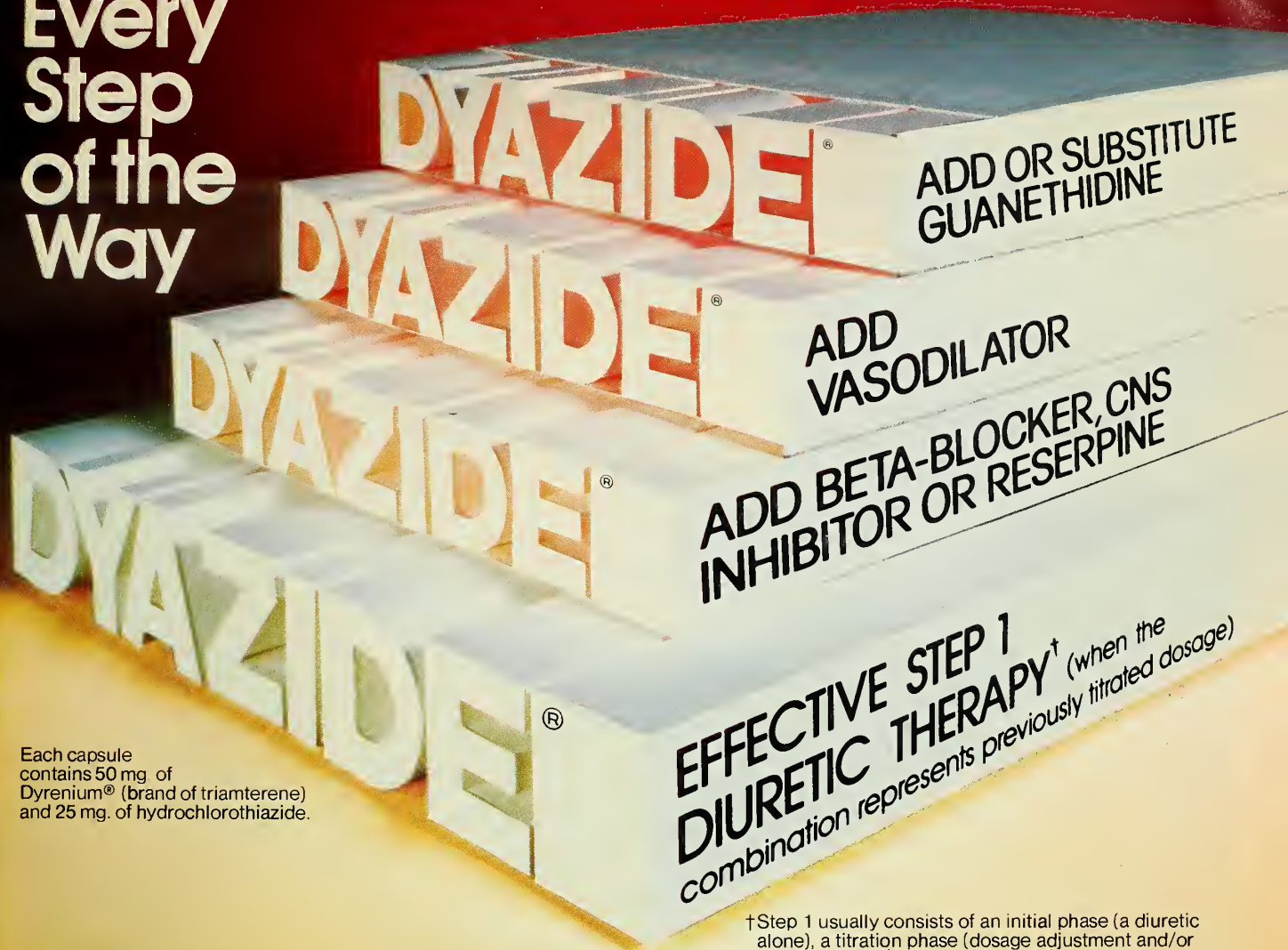
Information on various products, programs, etc., is received regularly by the IMS JOURNAL. Here are short items sifted from the mail by the Scientific Editor. A reference to a specific product is not intended to suggest any particular endorsement. Additional information on any entry may be obtained by contacting the IMS JOURNAL.

TWO NEW PRODUCTS — A. H. Robins has introduced two new products recently. Dimetane® Decongestant is for temporary relief of cold and allergy symptoms. Each 5 ml (1 tsp) of the red-colored, grape-flavored elixir contains phenylephrine hydrochloride, USP, 5 mg; brompheniramine maleate, USP, 2 mg; and alcohol, 2.3 percent. Each light blue, capsule-shaped tablet contains phenylephrine hydrochloride, USP, 10 mg; and brompheniramine maleate, USP, 4 mg. The second product is non-prescription Mitrolan® (brand of calcium polycarbophil). It is a hydrophilic bulk-producing stool normalizer for the treatment of constipation and diarrhea as associated with irritable bowel syndrome and diverticulosis. In diarrheal state, Mitrolan absorbs excess fecal water by forming a gel in the lumen of the intestine and producing a formed stool. In constipation, the product retains water in the lumen, opposing the normal dehydrating forces of the bowel. It became available in September.

FOR KIDNEY PATIENTS — FDA approval has been given a new Upjohn Vitamin D compound for bone problems associated with kidney failure. The name is Calderol Capsules (25-hydroxyvitamin D₃). The medication is of potential benefit to the nation's 46,000 dialysis patients and other kidney disease victims who face the threat of bone breakage. In studies of about 500 patients over 5 years the medication has been shown to help normalize the levels of calcium in the blood and strengthen bones. The product is to be available by Rx in the near future.

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Warnings: Do not use potassium supplements, dietary or otherwise, unless hypokalemia develops or dietary intake of potassium is markedly impaired. If supplementary potassium is needed, potassium tablets should not be used. Hyperkalemia can occur, and has been associated with cardiac irregularities. It is more likely in the severely ill, with urine volume less than one liter/day, the elderly and diabetics with suspected or confirmed renal insufficiency. Periodically, serum K⁺ levels should be determined. If hyperkalemia develops, substitute a thiazide alone, restrict K⁺ intake. **Associated widened QRS complex or arrhythmia requires prompt additional therapy.** Thiazides cross the placental barrier and appear in cord blood. Use in pregnancy requires weighing anticipated benefits against possible hazards, including fetal or neonatal jaundice, throm-

bocytopenia, other adverse reactions seen in adults. Thiazides appear and triamterene may appear in breast milk. If their use is essential, the patient should stop nursing. Adequate information on use in children is not available. Sensitivity reactions may occur in patients with or without a history of allergy or bronchial asthma. Possible exacerbation or activation of systemic lupus erythematosus has been reported with thiazide diuretics.

Precautions: Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids). Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics or those with suspected or confirmed renal insufficiency. Watch for signs of impending coma in severe liver disease. If spironolactone is used concomitantly, determine serum K⁺ frequently; both can cause K⁺ retention and elevated serum K⁺. Two deaths have been reported with such concomitant therapy (in one, recommended dosage was exceeded, in the other serum electrolytes were not properly monitored). Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving triamterene, and leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with thiazides. Triamterene is a weak folic acid antagonist. Do periodic blood studies in cirrhotics with splenomegaly. Anti-hypertensive effect may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients. The following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with

possible metabolic acidosis. 'Dyazide' interferes with fluorescent measurement of quinidine. Hypokalemia, although uncommon, has been reported. Corrective measures should be instituted cautiously and serum potassium levels determined. Discontinue corrective measures and 'Dyazide' should laboratory values reveal elevated serum potassium. Chloride deficit may occur as well as dilutional hyponatremia. Serum PBI levels may decrease without signs of thyroid disturbance. Calcium excretion is decreased by thiazides. 'Dyazide' should be withdrawn before conducting tests for parathyroid function.

Diuretics reduce renal clearance of lithium and increase the risk of lithium toxicity.

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Colleges shouldn't have to choose between lighting their buildings and enlightening their students.

—Thomas Edison
Inventor

There's nothing more frustrating for a scientist than to be on the verge of a great discovery and not be able to afford the equipment he needs. I know.

When I was a boy, I had to work overtime to get the money I needed for equipment. But somehow I eventually got what I had to have for my experiments.

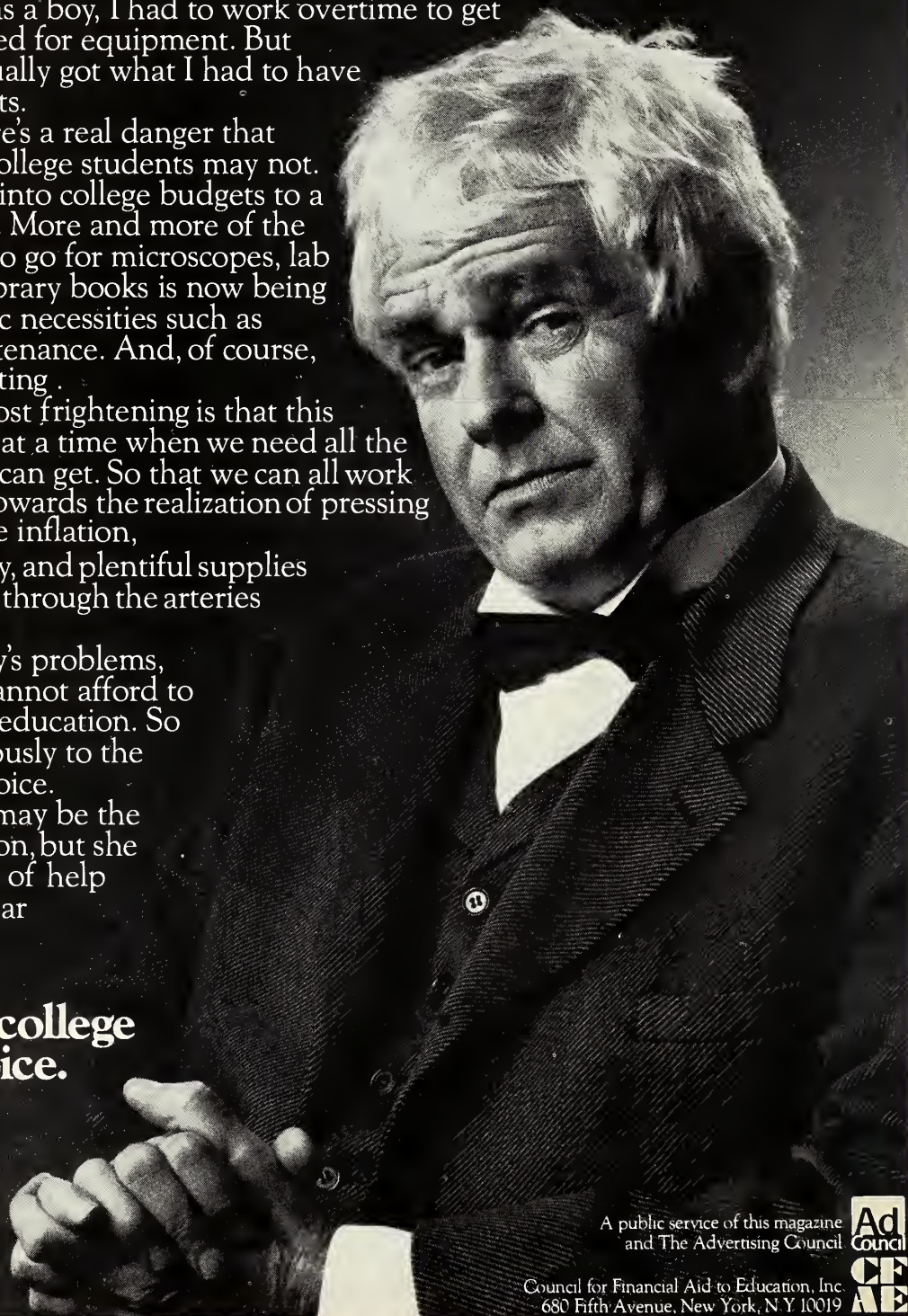
Today there's a real danger that many American college students may not. Inflation is eating into college budgets to a dangerous degree. More and more of the money that used to go for microscopes, lab equipment and library books is now being consumed by basic necessities such as heating and maintenance. And, of course, my specialty — lighting.

What is most frightening is that this squeeze is coming at a time when we need all the trained minds we can get. So that we can all work more effectively towards the realization of pressing goals: manageable inflation, revitalized industry, and plentiful supplies of energy coursing through the arteries of this country.

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OUR MAN ON EDUCATION

RICHARD M. CAPLAN, M.D.

ARE YOU (A) PROFESSIONAL?

THE LITTLE WORD "a" in the title makes lots of difference. Grammatically, it changes "professional" from an adjective to a noun. But it makes you realize that, in modern usage anyway, many persons may be professional in their behavior without being professionals. They may be skilled, practiced, adroit, effective, expert, accomplished — all these meaning simply the person is good-at-it. This could apply to a con-man. Professional also refers to

"The professional recognizes and accepts the idea of consumer control. He willingly encourages and cooperates with citizen (patient) population."

one who is making a living or at least charging a fee for what amateurs do for a pastime. Of course, the adjective also traditionally means "pertaining to a profession." But when one is a professional (noun), according to my dictionary, the person is "engaged in a profession, especially law, medicine or the ministry, or of a vocation requiring specialized training in the field of learning, art, or science."

A physician colleague who first made me think about the word once added some other attributes: 1) *professionals try to help persons need-*

ing help; 2) professionals engage in continuous learning; and 3) professionals police themselves and each other.

I think of all this now because of the appearance of a new measuring instrument of social psychology: The Health Care Professional Attitude Inventory of Dumont. It is based on the premise that professional life is experiencing a profound redefinition to meet the demands of constantly changing environments. Here are the underlying constructs for this inventory and its scoring:

1) The professional recognizes and accepts the idea of consumer control. He willingly encourages and cooperates with citizen (patient) participation.

2) The professional is *indifferent to credentials*: reward systems should be tied to actual effectiveness rather than "artifacts of authority" such as academic degrees or number of publications.

3) The professional has a sense of *superordinate purpose*: the ultimate and most salient purposes of the separate professionals are the same — the well-being of people.

4) The professional possesses an *attitude of criticism*: he is characterized as searching, questioning, skeptical; he wants to know what the evidence is and what the alternatives are.

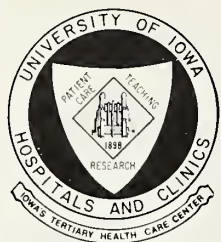
5) The professional is *impatient with the slow rate of change*: he sees his professional activities as needing a quick payoff in social accounts, for social change is no longer a matter of progress, but of survival.

6) The professional is driven by *compassion*: a *sensitivity and dedication to the needs of his client public* provides the orientation of his professional life.

Numbers 3, 4 and 6 seem to me very old-fashioned, really, and not likely to draw much protest from physicians. Numbers 1, 2 and 5 on the other hand might raise your hackles. Do you, for instance, sense your own adrenalin pumps turning on as you re-read those and think about their implications? Without arguing for one particular position over another, I ask you to remember that if you want to hold on to the present — or yet, the past — and tolerate no change, you are doomed to lose. Perhaps you can stave off major changes in the short run, but in the long run, they will occur. It merely remains to be determined *which* changes. How many "eternal verities" are really eternal? — *that's a long, long time.*

Dr. Caplan is Associate Dean for Continuing Medical Education at The University of Iowa College of Medicine.

DRUG THERAPY REVIEW



UNIVERSITY OF IOWA HOSPITALS AND CLINICS

REYNOLD SPECTOR, M.D., Editor

Editor's Note — In a previous issue of this JOURNAL, Dr. T. Vargish, Department of Surgery discussed prophylactic antibiotics in general surgery. In the following article, Dr. Sam Donta, Department of Medicine, presents his views. Both authors agree that, if used, prophylactic parenteral antibiotics should not be continued for more than 48 hours.

PROPHYLACTIC ANTIBIOTICS IN GENERAL SURGERY: A MEDICAL OPINION

Most surgeons now routinely administer antibiotics prophylactically prior to and for a few days following various surgical procedures. Much of this practice is based on many reports that espouse this approach, combined with the obvious appeal of a potential reduction in postoperative infection rates. This review will focus on the rationale and evidence that support the perioperative use of antibiotics in abdominal surgery.

This information for Iowa physicians is furnished and sponsored by the University of Iowa Hospitals and Clinics.

Two approaches, basically, have been used in an attempt to reduce and prevent postoperative infection following surgery involving the bowel. One of these involves the use of orally administered, nonabsorbable antibiotics in conjunction with mechanical cleansing of the gut. The other approach utilizes parenteral antibiotics. Historically, the use of preoperative laxatives and enemas gained general favor as a means of reducing the total bacterial mass prior to colonic surgery. While several reports questioned the efficacy of this form of bowel cleansing, most surgeons adopted this practice. The addition of a variety of absorbed and nonabsorbed antibiotics to this regimen produced a variety of conflicting reports and much debate, but the results of a VA cooperative study demonstrated a reduction in several types of more severe infections (e.g., peritonitis, bacteremia) with the use of orally nonabsorbed antibiotics (i.e., erythromycin base plus neomycin).¹

The second approach (i.e., parenteral antibiotics) gained impetus from the results of 2 separate studies. The first of these studies were those of Miles, Burke, *et al*, who showed that antibiotics given 1 to 2 hours prior to or after intradermal infection of animals could prevent the development of lesions.² Administration of antibiotic 3 hours post-infection was ineffective in preventing induration and inflammation. There are several drawbacks to Burke's studies. The model is of intradermal, not deeper, wound infection; it utilized a massive inoculum of organisms and did not evaluate the potential successful use of multiple doses of antibiotics. Subsequent to these studies, a variety of clinical trials employing different antibiotics was conducted and claims made both favoring and rejecting the use of perioperative parenteral antibiotics in abdominal surgery. The most notable of these was the study by Polk *et al*, claiming a significant reduction in postoperative wound infections following surgery on various segments of the GI tract, employing cephaloridine.³ In response to subsequent reports failing to show similar benefit, Dr. Polk has maintained the view that other cephalosporins (including cephalothin), do not attain the high tissue levels attained by cephaloridine. At this point, the argument would appear moot, as cephaloridine is not used much anymore because of its potential for nephrotoxicity.

No study has been conducted to compare the relative efficacies of parenteral antibiotics, mechanical cleansing, and oral, nonabsorbable antibiotics. A second VA cooperative study concluded that the addition of parenteral cephalothin to the mechanical-oral antibiotic regimen was of no greater benefit to the regimen without cephalothin in elective surgery of the large bowel.⁴ The use of cephalothin in combination with mechanical cleansing, but without oral antibiotics, was significantly worse than the mechanical-oral antibiotic regimen.

Apart from studies on patients undergoing elective colon surgery, the results of studies employing perioperative parenteral antibiotics in surgery involving the other segments of the GI tract, including pancreas and biliary tree, do not support the use of antibiotics in elective surgery involving these other intra-abdominal areas. This lack of efficacy in noncolonic surgery should not be surprising, as these other areas are normally uninhabited by organisms.

In evaluating the potential efficacy of prophylactic antibiotics in more emergent surgical situations, several factors need to be considered. First of all, such studies have not been conducted and would be difficult to do in humans because of greater variations from patient to patient and other variables in the emergency situation. Studies of this sort should probably be first conducted in experimental animal models. Secondly, if infection is already present or strongly suspected, then the situation may benefit better from approaches other than preoperative antibiotics. In these circumstances, a stronger case could be argued for surgical drainage of infected areas, tentative identification of the organisms involved, using stat gram stains and more defined use of antibiotics.

In considering the potential benefit of prophylactic antibiotic use, some attention needs to be given to the question of cost vs benefit. In evaluating this question, one ideally would like to know the prevailing postoperative infection rates and the nature of these infections. Are these infections prolonging hospital stay? Would the additional cost of antibiotics given to all patients result in net savings, as well as a significant reduction in infection rates? Additional attention needs to be given to means of reducing postoperative infection

rates not directly associated with the surgery (e.g., catheter-associated urinary tract infections, pulmonary infections). For those using prophylactic antibiotics, it would seem helpful to evaluate periodically the efficacy of this practice in terms of cost-benefit ratios, incidence rates, and the effects of antibiotics on the microbial flora. — *Sam T. Donta, M.D., Professor of Medicine, Director, Infectious Disease Services, U. of I. College of Medicine*

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STATE DEPARTMENT/ PUBLIC HEALTH

LOCAL BOARDS OF HEALTH

The local boards of health and their employees serve as the backbone for public health services in Iowa. The Local Health Act (Chapter 137, Code of Iowa) was passed in 1967. This law requires each county board of supervisors to appoint a 5-member board of health including at least one physician. The physicians of Iowa have risen to the challenge and have provided excellent service on the local boards of health. The knowledge and perspective they bring to the boards have been most valuable. It seems appropriate at this time to acknowledge and publicly thank the physicians who perform this service without pay. We have listed here the physicians who are currently members of county boards of health. We also take this opportunity to pay special tribute to those physicians who have served on their board of health for 10 years or more. We have identified each of these 22 dedicated physicians in the list by using an asterisk. Their long service to the citizens of Iowa is appreciated.

The local boards of health have continued to improve the public health services to Iowa communities. All counties in Iowa now have public health nursing services. In most coun-

ties this is a service under the local board of health. In a few it is provided by a visiting nurse association or under some other auspices. In all but 2 counties the nursing service is certified as a home health agency for Medicare-Medicaid. The boards of health also continue to expand their efforts in environmental health. The boards of health in 56 counties now employ environmental health workers.

The level of expenditures over the past several years reflects the increase in services provided. Inflation is another factor which must be considered when reviewing the increase in expenditures. In Table 1 we have shown the per capita expenditures for local board of health services for FY 73, FY 76 and FY 80. The last column shows the per capita expenditures for FY 80 from local tax funds or federal general revenue sharing funds. Although we do not have the detail data from earlier years to confirm it, the fee income and grants of state funds have risen much more in the past few years than the expenditure of local tax funds.

By law the cities over 25,000 can have a separate board of health. For simplicity in presenting the information in Table I we have combined the city and county expenditures and populations.

TABLE I
PER CAPITA EXPENDITURES FOR LOCAL BOARD OF
HEALTH SERVICES

Per Capita Expenditure	Based on Total Expenditures			Based on Local Tax or Federal Revenue Sharing
	# Counties FY 73	# Counties FY 76	# Counties FY 80	# Counties FY 80
.00 — .49	17	8		10
.50 — .99	14	4		16
1.00 — 1.99	41	25	3	40
2.00 — 2.99	16	27	10	15
3.00 — 3.99	7	15	19	13
4.00 — 4.99	3	7	27	4
5.00 — 5.99	1	8	13	
6.00 — 6.99		3	8	
7.00 — 9.99		2	16	1
Over 10.00			3	

This information on public health matters is furnished and sponsored by the Iowa State Department of Health.

(Please turn to page 120)

PHYSICIAN MEMBERS/COUNTY BOARDS OF HEALTH

Adair	P. G. Frankl, D.O.	Johnson	Charles A. deProsse, M.D.
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Clayton	Kenneth Zichal, M.D.	Plymouth	Daryl Doorenbos, M.D.
Clinton	George L. York, M.D.	Pocahontas	James Slattery, M.D.
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Jackson	Clifford Rask, M.D.	City of Council	
Jasper	R. F. Frech, M.D.	Bluffs	Lawrence Keefe, M.D.
Jefferson	T. J. Sutton, M.D.*		Dennis S. Jones, M.D.

In Table II we have summarized the data from the annual expenditure reports for all the city, county and district boards of health for July 1, 1979 — June 30, 1980.

The local boards of health play a vital role in public health in Iowa. We salute their efforts and accomplishments in improving the health and quality of life of Iowans. We thank the physicians for their participation on the boards of health.

TABLE II
ANNUAL EXPENDITURE SUMMARY

Expenditures	
Nursing Salaries	\$ 3,835,774.78
Environmental Salaries	1,663,501.07
Clerical Salaries	1,187,637.47
Other Salaries	1,685,946.14
Fringe Benefits	1,178,421.36
Travel	598,499.29
Grants or Reimbursement	
to Other Agencies	2,515,700.10
Other Expenses	<u>1,285,782.27</u>
Total Expenditures	\$13,951,262.48
Sources of Funds	
Local Tax	\$ 6,381,408.74
Federal General	
Revenue Sharing	399,633.85
Medicare Fees	1,355,358.90
Medicaid Fees	359,433.17
Other Nursing Fees	328,219.03
Environmental Fees	731,040.80
State Grants	3,139,265.76
Federal Grants	965,307.23
Other	<u>291,595.00</u>
Total Funds	\$13,951,262.48

GENETIC CONSULTATION

The Regional Genetic Consultation Service will conduct clinics in the following Iowa communities between March and June:

IN MARCH (dates follow the cities): Des Moines (5), Council Bluffs (11), Carroll (12), Davenport (19), Mason City (25 & 26), Burlington (26) and Waterloo (27). IN APRIL: Des Moines (1), Creston (2), Spencer (8), Sioux City (9), Dubuque (22) and Davenport (23). IN MAY: Ames (6), Des Moines (7), Fort Dodge (7), Davenport (14), Cedar Rapids (15), and Ottumwa (18). IN JUNE: Des Moines (3 & 4), Council Bluffs (10), Carroll (11), Davenport (11), Mason City (24), Waterloo (25 & 26) and Burlington (30).

The RGCS clinical director at the University of Iowa is James Bartley, M.D. Elizabeth Thomson, R.N., is the clinical coordinator. The RGCS has consultants in 5 Iowa locations as follows: Northeast — Donna Mihm-Falck, M.S., St. Luke's Hospital, Cedar Rapids; Southeast — Monica Wohlferd, M.S.S.W., Oakdale Hospital, Oakdale; Central — Diane Bierke-Nelson, M.S.S.W., 1308 Pleasant St., Des Moines; Southwest — Allyn McConkie, M.S.W., 1308 Pleasant St., Des Moines; Northwest — Carol Betts, R.N., 1012 Central Avenue, Fort Dodge.

Roger Chapman is administrator of the Birth Defects Institute at the Iowa State Department of Health in Des Moines. His telephone number is 515/281-6646.

MEDICAL ASSISTANTS' CONVENTION

The 1981 convention of the American Association of Medical Assistants, Iowa State Society, Inc., will be April 24-26 at the Blackhawk Hotel in Davenport.

A session of the organization's House of Delegates will precede the General Assembly at which President Doris Liggett, CMA-AC, will speak.

Current officers in Iowa medical assistant chapters include:

Siauxland — Gwen Jansen, CMA-A, president; Mary Bechler, CMA, vice-president; Helen Behrendt, secretary; and Janice Hala-han, treasurer. Des Moines — Ethel Kunkle, CMA, president; Christine Bartkiw, president-elect; Caralyn Pluck, CMA, vice-president; Marcia Day, secretary; and Twilla Thampson, treasurer. Blackhawk — Pat Peters, president; Carol Schatz, vice-president; Jessie Kutz, secretary; and Rita Myers, treasurer. Linn — Becky Bahnsen, president; Diane Uthoff, CMA, vice-president; Mary Early, president-elect; Karen Prull, secretary; and Laurel Duncan, treasurer. Scott — Mildred Rabesan, president; Nelda Pallner, vice-president; Barbara Gillaspie, secretary; and Carol Kurth, treasurer. Cerra Garda — Marilyn Just, president; Ja Siefken, vice-president; Larrie Hart, secretary; and Luann Engels, treasurer.

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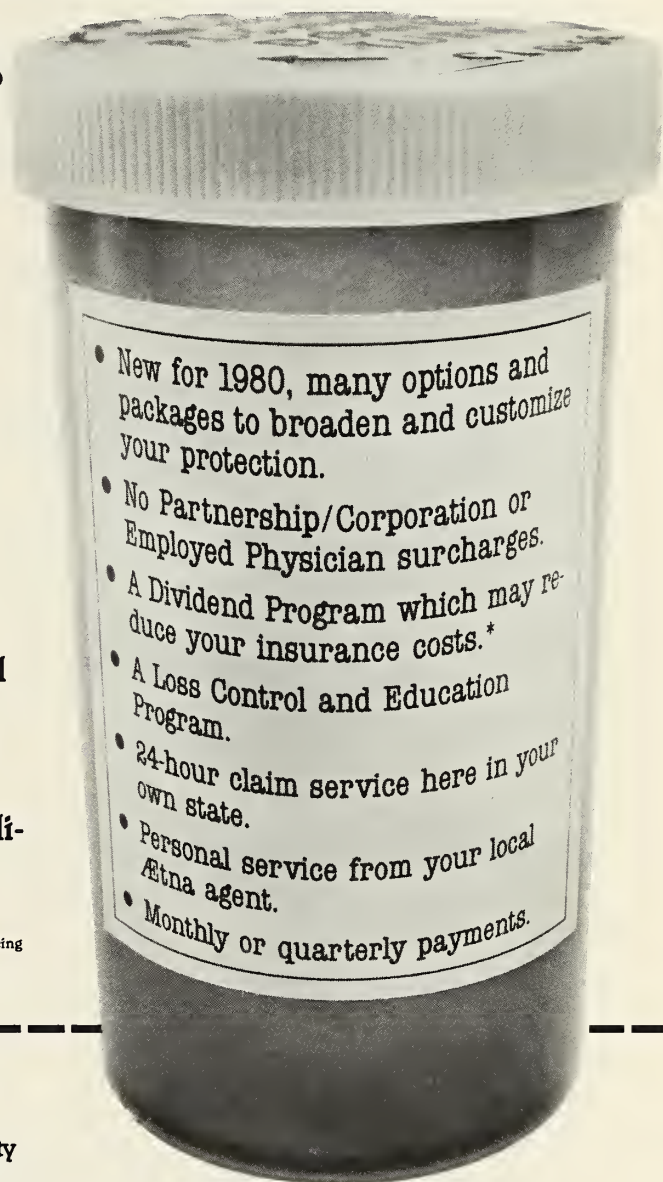
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January 1981 Morbidity Report

Disease	Jan. 1981 Total	1981 to Date	1980 to Date	Most Jan. Cases Reported From These Counties
Amebiasis	0	0	0	
Brucellosis	0	0	0	
Chickenpox	1358	1358	1106	Dubuque, Black Hawk, Jahnsan
Cytomegalovirus	2	2	1	Jahnsan, Scott
Eaton's Agent infection	3	3	1	Lee, Jahnsan
Encephalitis, viral	1	1	3	Jackson
Erythema infectiosum	163	163	1	Paweshiek
Gastroenteritis (GIV)	3000	3000	1667	Linn, Palk, Scott, Jahnsan
Giardiasis	6	6	1	Dubuque
Hepatitis, A	34	34	7	Scott, Palk, Appanaose
Hepatitis, B	7	7	8	Scattered
type unspecified	5	5	6	Scattered
Herpes Simplex	8	8	9	Jahnsan
Herpes Zoster	1	1	0	Jahnsan
Histoplasmosis	3	3	1	Dubuque, Jahnsan, Palk
Infectious mononucleosis	32	32	22	Linn, Palk, O'Brien
Influenza, lab confirmed	32	32	0	Scattered
Influenza-like illness (URI)	12175	12175	4482	Jahnsan, Pala Alta, Linn
Meningitis				
aseptic	6	6	4	Scattered
bacterial	17	17	9	Scattered
meningococcal	4	4	0	Palk
Mumps	8	8	8	Scattered
Pertussis	0	0	0	
Rabies in animals	55	55	24	Buena Vista, Jasper Jahnsan
Rheumatic fever	1	1	0	Linn
Rubella				
(German measles)	0	0	0	
Rubeola (measles)	0	0	1	
Salmonella	12	12	9	Scattered
Shigellosis	9	9	7	Jefferson
Tuberculosis				
fatal ill	9	9	5	Scattered
bact. pos.	9	9	4	Scattered
Venereal diseases:				
Gonorrhea	382	382	423	Palk, Black Hawk, Waadbury
Syphilis	1	1	2	Scott

Laboratory Virus Diagnosis Without Specified Clinical Syndrome: Adenovirus — 1, Wapella; Guillain Barre Syndrome — 1, Pattawatamie; Legionnaire's Disease — 1, Linn; Scarlet Fever — 2, Black Hawk, 1, Cherokee, 2, Dallas, 1, Linn, 5, Palk; Campylobacter — 2, Dubuque, 2, Palk; Toxic Shock Syndrome — 1, Webster.

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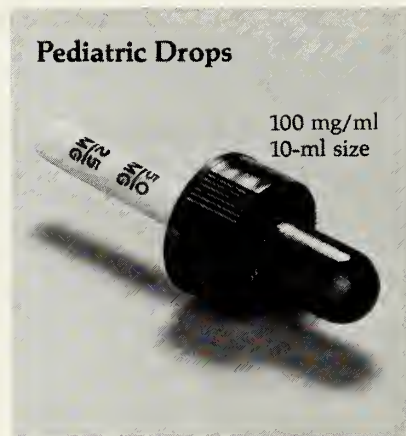
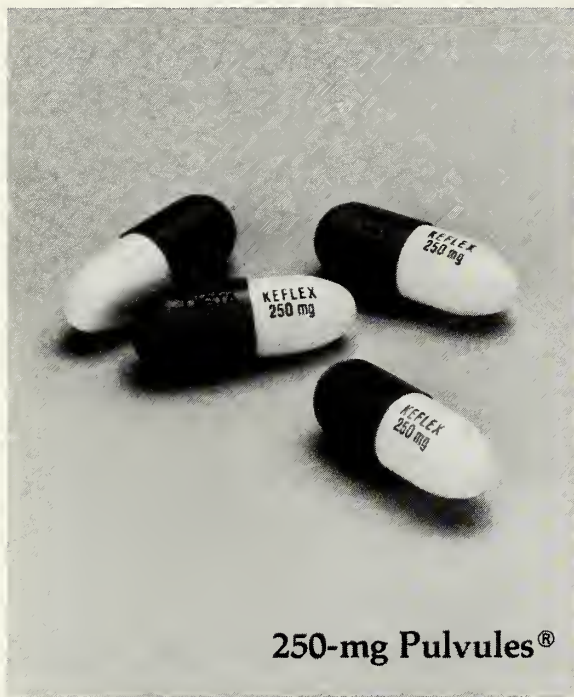
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ABOUT IOWA PHYSICIANS

Drs. James F. Boysen, Leonard Boggs, and Alf Jordan, Sioux City physicians, were guest speakers at a recent perinatal conference in Sioux City. The conference was presented by St. Luke's Medical Center in cooperation with the University of Iowa College of Medicine and the Iowa Statewide Perinatal Care program. . . . Dr. John Roberts has been named president of the Woodbury County Medical Society; Dr. Daniel Youngblade, president-elect; Dr. J. Scott Pennepacker, secretary, and Dr. John Baller, treasurer. All are Sioux City physicians. . . . Dr. R. L. Emerson, Mason City, was guest speaker at the January meeting of the Wright County Medical Society. Dr. Emerson discussed low back pain. . . . Dr. Alan R.

Swearingen, Bettendorf, is 1981 president of the Scott County Medical Society. Other 1981 officers are — Dr. Patrick G. Campbell, president-elect; Dr. Steven C. Johnson, secretary, and Dr. Eugene Hoenk, treasurer. All are Davenport physicians. Dr. John A. Caffrey, Des Moines, recently received the Creighton University School of Medicine Silver Anniversary Citation.

Dr. James Bloom will join Charles City physicians, Dr. Hillard A. Tolliver and Dr. Donald L. Trefz, in July. Dr. Bloom received the medical degree at the U. of I. and completed his family practice residency at St. Joseph Mercy Hospital in Mason City.

DEATHS

Dr. George E. Mountain, 69, Des Moines, died January 12 at Iowa Methodist Medical Center. Dr. Mountain received the M.D. degree and served his residency in internal medicine at Northwestern University School of Medicine. A lifelong Des Moines resident, Dr. Mountain

(Continued on page 126)

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(Continued from page 125)

was a trustee of Drake University and member of the American College of Physicians; American Society of Internal Medicine; American Mutual Life Insurance board of directors; and Des Moines Medical Library Club.

Dr. Ward A. DeYoung, 84, longtime Glenwood physician, died January 3 at his home in Saugatuck, Michigan. Dr. DeYoung received the M.D. degree at Rush Medical School in Chicago. He began his practice of medicine in Glenwood in 1931, retiring in 1971. Dr. DeYoung was a former member of the medical staff at Mercy Hospital in Council Bluffs and served as county coroner and Burlington Northern Railroad physician.

Dr. Carl V. Bisgard, 76, Harlan, died January 18 at his home. A native of Harlan, Dr. Bisgard received the M.D. degree at Harvard Medical School. He began his practice of medicine in Harlan in 1934, retiring in 1974.

Dr. William J. Kelly, 82, died January 24 at Xavier Hospital in Dubuque. Dr. Kelly re-

ceived the M.D. degree at Loyola University School of Medicine. He joined Medical Associates in Dubuque in 1944, retiring in 1965.

Dr. Alfred N. Smith, 60, Des Moines, died February 1 at Iowa Methodist Medical Center. Dr. Smith received the M.D. degree at U. of I. College of Medicine. He was a fellow of the American College of Surgeons; diplomate of the American Board of Surgery; member of American Society of Contemporary Medicine and Surgery; and Iowa Academy of Surgery. A World War II veteran, Dr. Smith was retired chief of staff at Veterans Administration Medical Center in Des Moines.

Dr. Luke A. Faber, 74, Dubuque, died January 27. Dr. Faber received the M.D. degree from Northwestern University College of Medicine and practiced in Dubuque until his retirement in 1976. He was a past president of the Dubuque County Medical Society; fellow of the American College of Surgeons; and life member of the Iowa Medical Society. Among the survivors are two sons, Dr. Luke C. Faber, and Dr. Denis D. Faber, both of Dubuque.

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Good Progress For QCHP



IN MID-1980 the Quad City Health Plan became operative. We discussed that beginning. Now, 9 months later, it is proper to provide a status report.

How is the QCHP doing?

"The plan is pretty much on target and on budget. We targeted for about 10,000 enrollees by the end of the first year and we expect to exceed that just slightly. The physicians' fund looks like it is going to pay 100% of the approved fee schedules."

These are the upbeat comments of Robert J. Ketelaar, M.D., Davenport, president of the Eastern Iowa Individual Practice Association, one of three IPA's associated with the new HMO.

From the statistical standpoint, QCHP began officially in Iowa in June 1980. Its enrollee ranks include 10,173 Deere employees as this is written. The percentage of Deere workers selecting the new option is about 30%. QCHP has 148 physicians participating in its affiliated IPA's.

As followers of Iowa health care delivery generally know, the QCHP is a prepaid plan now limited to employees of Deere and Company. It was described as follows in a February 9 speech in New York City given by Duane H. Heintz, manager, health care services for Deere:

"The first HMO we've helped to establish is the Quad City Health Plan geographically located on the Eastern Iowa-Western Illinois border — an area of approximately one-half million people. The Health Plan (HMO) is an IPA model wherein existing physical facilities are utilized; existing physician-patient hospital relationships are preponderantly unchanged; the traditional fee-for-service reimbursement mechanism is maintained intact (although physicians are at risk for excesses); the availability, quality and accessibility of services are enhanced; and utilization of services becomes more appropriate in terms of necessity and appropriateness of setting."

Orderly expansion of the QCHP to other

major area employers is expected. Current overtures are being made to Caterpillar, a manufacturer with approximately 10,000 employees. Other major employer prospects in the area are J. I. Case, Alcoa and International Harvester.

"We don't want to overwhelm ourselves with enrollees," says Lloyd Mathwick, the QCHP executive director. "We plan to invite consideration by the bigger employers on a one-at-a-time basis."

Mathwick explains the current monthly rate of \$35.50 per capita is holding well. There is hope that little, if any, rate increase will be needed as the second year begins.

The first year arrangement will continue with IPA physicians receiving 90% of their filed fees as services are provided. The remaining 10% is to be paid at the year's close depending on the condition of the IPA fund. "It looks like he (the physician) will receive his 10% without any question this first year," adds Mathwick.

One bright early sign is the use of inpatient hospital days. Annualized days of acute hospitalization have been tabulated at 533 per 1,000 enrollees. This compares with about 950 days per 1,000 for the general Iowa population.

These comparisons bear out the aggressive effort to encourage lower cost ambulatory care. Careful monitoring by IPA peer review committees is undertaken to assure inpatient care is maintained at prescribed levels; where a Plan doctor believes additional hospital days are necessary a second opinion must be obtained.

It's been a lot of work to date. No one denies that. Says Dr. Ketelaar: "For those physicians in the Plan there seems to be good acceptance, and even enthusiasm on the part of a fair number. On the part of those physicians who are not in the Plan, we are not receiving a lot of open criticism."

"We don't feel compelled toward a rapid growth scenario because there are a lot of hazards in progressing faster than your service potential. We are optimistic that plans such as this can be made to work to provide comprehensive and quality coverage to enrollees at a reasonable and competitive cost."

March 1980

Journal of the Iowa Medical Society

THINGS YOU SHOULD KNOW

1981 HOUSE OF DELEGATES

May 2/3 are dates of the 1981 session of the IMS House of Delegates. County societies are urged to have their full complement of delegates in place at the Hotel Fort Des Moines. The 2-day policy-making event is open to any interested member.

RESOLUTIONS COMING

An upsurge in resolutions indicates a busy House session is in store. 15 petitions are in hand as TYOTK is written. Resolution topics include Medicaid fees, use of EMT's, nursing home regulations, frequency of school athletic physicals, encroachment by Board of Medical Examiners, availability of rabies vaccine, etc.

DELEGATES HANDBOOK

Resolutions, reports, etc., are contained in the 1981 Handbook for the House of Delegates mailed in late March to those physicians who'll represent their colleagues at the IMS House session in May. The Handbook contains committee and council highlights for the IMS year.

CME FORM AGAIN

A much-condensed 1981 continuing education form is being sent to Iowa physicians by the Board of Medical Examiners. The CME report form is to be distributed with license renewal applications in late March or early April. IMS members should be on the watch.

EVERYTHING'S UP TO DATE

In Kansas City. Site of the 1981 IMS Scientific Session. Meet your annual CME requirements (in part) in this relaxing, family-oriented way at the Alameda Plaza Hotel in K.C. Full details available from IMS headquarters; call 1/800-422-3070 outside Des Moines; 223-1401 inside Des Moines. Scientific Session dates are June 24 to 26.

SEEK PRECEPTORS

Iowa family physicians are needed as preceptors for junior medical students. A 2-week preceptorship is provided to acquaint junior students with private family medicine practice. Interested physicians may contact Charles Driscoll, M.D., Family Practice Department, Room 167, Children's Hospital, Iowa City 52242.

MEET WITH FARM BUREAU REPS

Iowa Farm Bureau President Dean Kleckner and several fellow officers shared with the IMS Board of Trustees in an informal late February discussion of medical care issues. The Farm Bureau sponsors the largest group health coverage in Iowa, providing for some 70,000 citizens through Blue Cross/Blue Shield. Cost matters dominated the positive IMS/IFB meeting.

ADOLESCENT HEALTH

The third Conference on Adolescent Health will be May 4 at ISU's Scheman Center in Ames. This event is co-sponsored by the IMS, State Department of Health, and ISU Extension Service. Key-note will be Elizabeth Jerome, M.D., director, Teenage Medical Services, Childrens Health Center, Minneapolis. The session is for teenagers, their parents and providers of service. More info available on request.

1981 HAWKEYE SCIENCE FAIR

For another year the Iowa Medical Society and the Iowa Medical Society Foundation (Scanlon Foundation) join Drake University and the Des Moines Register and Tribune to sponsor the Hawkeye Science Fair. April 3/4 are dates of this year's youth science education program at the Veterans Auditorium in Des Moines.

The Continuous Quest

JOHN W. ECKSTEIN, M.D.

Iowa City, Iowa

The quest for new knowledge goes on and on. It is called research and is a natural extension of teaching. It is woven tightly into the fabric of the University of Iowa College of Medicine. So says Dean John Eckstein in his 1981 comments to IMS JOURNAL readers. He lauds the 20-year efforts of the U. of I. Clinical Research Center, one of the nation's earliest, and he expresses concern for its survival.

IT IS AXIOMATIC in medicine that nothing comes easy. To reach the present state of the art, generations of physicians and scientists have hypothesized, tested, treated, overcome discouragement, shared triumphs and disappointments — and never allowed themselves to think for a moment that they had finally reached their ultimate goals.

It was always thus, as indeed it continues to be — presumably forever, since the pursuit of answers invariably generates new, intriguing and important questions. This certainty is itself a powerful motivator for the study and practice of medicine; here it exists to a degree found in few other occupations.

Whether because so many Iowans have been close to the land and hence to all nature, or because we are simply a practical people much given to independent problem-solving and

search for answers, this state has a long tradition of appreciation and support for research. The College of Medicine is the beneficiary of that tradition in many ways, with research flowing naturally from the teaching function: the continuous challenge of curious, young, active minds reacting to the thoughts and forays into the unknown by their teachers, in whom the need always to know more is a dominant trait.

NAMES TO REMEMBER

Those who have studied medicine at the University of Iowa have known of, and in some cases have been involved in, the rich tradition of clinical investigations and laboratory studies. Out of this have come notable contributions to the knowledge and practice of medicine. Students of the 1930's and later, for instance, were familiar with the work of internationally recognized urologists Dr. Nathaniel G. Alcock, known for his developments in transurethral surgery, and his successor, Dr. Rubin H. Flocks, a leader for many years in the treatment of prostatic disease.

Many others remember the wide-ranging research of biochemists Drs. Robert B. Gibson and Henry A. Mattill. Dr. Gibson was the first scientist to describe the efficacy of whole liver in the treatment of pernicious anemia, which preceded the development and use of liver extract. Dr. Mattill won national recognition for his thorough studies on nutrition, particularly for his outstanding investigations on the chemistry and physiological action of vitamin E and other antioxidants.

Other outstanding Iowa investigators of

years past come easily to mind: the classic cardiovascular experiments of Dr. Fred M. Smith in internal medicine; extensive studies of morphine by Drs. Oscar H. Plant and Erwin G. Gross in pharmacology; the orthopaedic skills of Drs. Arthur Steindler and Carroll B. Larson; the nutritional research of Dr. Philip G. Jeans; and the work of Drs. Emory D. Warner and Kenneth Brinkhous, pathologists who were at the forefront of research in blood coagulation, vitamin K, and hemorrhagic diseases.

CLINICAL RESEARCH CENTER

In large part because of Iowa's solid tradition in medical research, the College of Medicine in 1961 was awarded one of the nation's earliest Clinical Research Centers, funded by the National Institutes of Health. The CRC provides an environment for biomedical scientists to study disease processes under ideally controlled clinical conditions that produce the most reliable results.

IN 1981, THE COLLEGE OF MEDICINE WILL TEACH
. . . Some 400 resident physicians and more than 100 clinical and research fellows . . . 700 medical students . . . more than 900 dentistry, pharmacy, and nursing students . . . about 280 students in allied health fields . . . nearly 350 students in the master's, doctoral, and postdoctoral programs in the basic sciences, and the Graduate Program in Hospital and Health Administration . . . and more than 2,000 students in the University's undergraduate arts and sciences programs.

With its 16 beds, Iowa's CRC is one of the larger such units in the nation. In it, College of Medicine faculty members carry out studies to learn more about normal and abnormal body functions, as well as the cause, progression, control, prevention, and cure of disease — then translate these advances into effective patient care.

Typical of the research carried out in this unit by members of the clinical faculty and subsequently shared with other Iowa practitioners would be the long-term study of muscular dystrophy which has led to elucidation of genetic transmission, unusual clinical variants, diagnostic tests and biochemical abnormalities in muscle protein synthesis.

Some of the early studies done in the Clinical Research Center determined the usefulness of beta blockade in the treatment of thyrotoxicosis



John W. Eckstein, M.D.

and cardiac arrhythmias. Other widely known CRC studies include those on the effectiveness and complications of gastric bypass for the treatment of morbid obesity, and on the pharmacokinetics of theophylline for use in the treatment of asthma. The latter research has unequivocally shown the value of theophylline treatment and resulted in specific recommendations for optimal drug dosage.

A multidisciplinary study of patients with prolactin-secreting pituitary tumors, recently carried out in the Iowa Clinical Research Center, demonstrated the effectiveness of transphenoidal pituitary surgery for the treatment of this disorder that results in the restoration of fertility in previously amenorrheic women.

IOWA CRC SURVIVAL

These are just illustrative of the great variety of studies whose results have been shared with the practicing profession by means of faculty visits to Iowa practitioners, a variety of continuing education programs, and by articles in the *IMS JOURNAL* and other appropriate professional journals. Unlike many of the other Clinical Research Centers which lost their federal funding and passed out of existence, the University of Iowa CRC has been continually funded by the NIH over its 20-year life — but whether the current grant will be renewed af-

ter it expires in August, 1982 is a matter of great concern to us, in view of the new Administration's budget-cutting efforts.

IN 1981, THE COLLEGE'S OFFICE OF CONTINUING MEDICAL EDUCATION WILL . . . Sponsor or co-sponsor some 250 formally structured continuing education programs, taking place in Iowa City and other communities throughout the state . . . Record about 10,000 registrations (82% Iowans) . . . Attract more than 70 different occupations and about 80% of Iowa's medical practitioners . . . Continue to provide a speaker's bureau service; arrange individualized traineeships for practitioners (1 to 30 days); and provide information or educational counseling for individuals, groups and agencies.

Medicine, of course, needs both clinical and laboratory research to solve the health problems which continue to plague mankind — perhaps especially those problems which cost so much to treat and cure. American medicine is among the best in the world in finding ways to alleviate or correct disorders after they have developed — we are great at applying life-saving heart surgery techniques, for instance, but the ultimate objective of medicine must be to prevent the need for such surgery from developing. We are skilled at diagnosing end-stage kidney disease, and we can deal with it, at great cost, by dialysis and transplantation — but we need sure knowledge of what causes the condition.

NEED TO KNOW

This need to know more is what motivates researchers to study a colony of aging monkeys, for instance, in a search for means to prevent arteriosclerosis. Another study currently under way involves the central nervous systems of hypertensive rats. Other Iowa researchers study nephropathy among diabetics. Any or all of their findings may ultimately aid in clarifying the causes of end-stage kidney disease.

A possible treatment for the toxic effects of methyl alcohol is being studied by a pharmacologist, who tests in monkeys the effect of injections of folic acid and some of its derivatives in pursuing a more readily available

alternative to hemodialysis, and a possibly safer alternative to ethyl alcohol therapy.

Although Legionnaires disease is no longer a mystery, an Iowa microbiologist continues to study *Legionella pneumophila* in the hope of enhancing our general knowledge of sporadic pneumonias and how to treat them.

Meanwhile, a physiologist is "pinning down" the actual extent of the damage, often irreversible, that high school wrestlers are doing to their bodies through some of the drastic means they employ to "make weight." And an Iowa biochemist works with compounds that interact with hemoglobin S and prevent it from aggregating within the red blood cell, aiming at high specificity for the hemoglobin molecule and potent inhibition of the blood-sickling process.

IN 1981, THE COLLEGE'S OFFICE OF COMMUNITY-BASED PROGRAMS WILL . . . Continue coordination of the Statewide Family Practice Training Program, which has a projected 1981-82 enrollment of 181 resident physicians . . . Provide technical assistance to Iowa communities interested in physician recruitment . . . Seek to attract more residency-trained family physicians into small group practice arrangements in physician shortage areas through the Rural Medical Service Development Program . . . Continue operation of the Physician Data Systems, which helps the College and community-based residency directors to evaluate the progress of the programs and chart medical manpower trends in Iowa . . . Organize and support the annual Iowa Family Practice Opportunities Fair . . . Provide a wide range of services for physicians in training who are interested in Iowa medical practice opportunities.

Again, these are but a few illustrative examples of the search in laboratory and clinic for knowledge which can be applied in medical practice and shared with patients. If prevention is indeed to be the next big breakthrough, as has been widely suggested, many questions of cause and effect remain to be answered before our profession can achieve that ideal for our patients. Hence our continued concern for new knowledge through research, which we see as a completely natural extension of our primary teaching function in the College of Medicine.

Looking at the teaching hospital in the emerging economic climate is a challenging assignment. Sustaining the progress must be our earnest and cooperative pursuit. So says John W. Colloton, director, University of Iowa Hospitals and Clinics, and immediate past chairman, National Council of Teaching Hospitals. Colloton currently serves with Dean of Medicine John W. Eckstein, M.D., on the executive council of the Association of American Medical Colleges, and has two major committee assignments in the American Hospital Association.

Questions/Answers: THE TEACHING HOSPITAL

JOHN W. COLLOTON

Iowa City, Iowa

What are the major problem areas with which teaching hospitals will have to contend in the 1980's?

The 1980's promise to be exciting years, challenging the nation's teaching hospitals to sustain their unprecedented record of societal contribution in an increasingly cost-conscious environment. Attention is being focused by the Reagan administration on "competitive" alternatives which could revolutionize the system of financing health care in this nation. Competition is viewed as a means to provide incentives to both consumers and providers to modify their behavior in a manner designed to encourage cost consciousness, reduce demand for services, and trigger other changes in the delivery system.

Any significant change in the present system of financing medical care must be preceded by a careful analysis of the implications for graduate medical, dental and other educational programs, in addition to clinical research support and a host of other societal contributions emanating from teaching hospitals.

These vital functions must have a secure financial base to assure the ability of our nation's teaching hospitals to continue meeting society's need for both skilled clinicians and ever-improving clinical tools. Financial considerations in competition proposals must also be accompanied by attention to the potential impact on well-established patient care networks that are critical for education, research and efficient and effective delivery of specialized medical services.

During the decade ahead, teaching hospitals must also grapple with issues relating to the changing mix and role of health professionals. Many authorities, including the federal government, are projecting a *national* surplus of physicians in the coming years. These projections are causing a shift in federal policy in several areas, including the withdrawal of general support allocations to medical schools which were initiated in the 1960's when the government wished to induce greater medical school enrollment. The nation's university health centers must develop innovative methods to meet society's continuing demand for primary care physicians, particularly in an era of decreasing federal support for medical and other health education, without damaging the patient care capacity of teaching hospitals.



John W. Colloton

Teaching hospitals, in common with all other levels of the health care system, must also address the problems created by the critical shortage of registered nurses that currently exists nationwide and is projected to increase in the years immediately ahead.

Finally, the 1980's will present challenging ethical dilemmas as advances of the "new biology" bear fruit. The implications of recent discoveries in the fields of genetics and cellular biology will engage a wide spectrum of medical scientists and other expertise in a continuing dialogue to determine the proper application of these advances to clinical practice.

How does the teaching hospital of today differ significantly from those of past generations?

A portrait of yesterday's teaching hospital is characterized by an image of a large, highly-subsidized, usually antiquated, generally urban hospital serving a huge indigent patient population. Those teaching hospitals provided primary and specialty care employing the latest in medical technology and formed the genesis from which the teaching hospital of today evolved.

The contemporary teaching hospital has been shaped and molded by multiple forces within our health care system and society at large. First, science and technology have merged to create:

- A knowledge explosion emanating from a more than \$2 billion annual investment in the National Institutes of Health leading to increased specialization and a natural stratification in the delivery of health services. This in turn has resulted in a significant growth in the number of physicians and other health professionals nationwide.

- Innovative technological breakthroughs such as cardiac imaging, electron microscopy, cytogenetic testing, kidney and bone marrow transplantation and many others have emerged, resulting in tertiary-level teaching hospitals making huge investments in the development, testing and use of this exciting technology.

- A concentration of highly specialized clinical and professional expertise has enabled teaching hospitals to use these scientific and technological advances in a high-quality, cost-effective manner. Around-the-clock availability of clinical and professional staff in all specialties and critical linkages between medical science and engineering have been formed in teaching settings to assure appropriate and effective use of state of the art resources to optimally meet the needs of patients referred by community physicians.

IN 1981, UNIVERSITY HOSPITALS WILL . . . See the number of Iowans tested for glaucoma with the Iowa Lions Club - Department of Ophthalmology mobile unit pass 100,000 (the program began in 1965) . . . Offer consultation and management advice through the Genetic and Metabolic Screening Clinic . . . Coordinate the Regional Genetic Consultation Service, which in 1979 counseled 972 families at 15 regional clinic sites and 800 at University Hospitals, and which has provided some 600 educational programs in the past four years.

The University of Iowa Hospitals and Clinics is on the cutting edge of frontiers in science and medicine as reflected in the multiple tertiary services currently being provided for Iowa's citizens in support of community practice. Within this highly coordinated clinic and hospital setting, 937 physicians currently serve Iowa physicians and their patients, through 16 clinical services encompassing 91 recognized specialty and subspecialty fields. This concentration of highly specialized resources constitutes a major resource in Iowa's stratified health care system.

Second, the nearly universal expansion of basic health insurance protection since the mid-1960's, provided through both private and governmental initiative, has precipitated a reduction in the medically indigent population and led to significant numbers of self-pay patients being referred to modern-day teaching hospitals. Coordinate with these changes in

IN 1981, UNIVERSITY HOSPITALS WILL . . . Provide 10 educational programs with 70 courses and some 4,500 participants through the Emergency Medical Services Learning Resources Center . . . Continue epidemiology consultation for 119 of the state's 137 hospitals in the area of infection control . . . Direct comprehensive follow-up care for some 220 patients in the Rural Comprehensive Care Program for Hemophilia Patients, with the participation of 108 community physicians and 95 dentists.

financing has come a consciousness in teaching hospitals of the need to deliver one-class, high-quality care to *all* citizens irrespective of the patient's economic status in life. An abundance of policies and programs were developed over the past decade at the University of Iowa Hospitals and Clinics to respond to this need for the delivery of a single class of humanistic patient service. Policy positions embodied in a "Guiding Principles of Patient Care" statement were adopted; a statement of interprofessional conduct establishing an institutional standard of behavior in doctor/patient relationships and in relating to community physicians throughout the state and region was also developed; and a Patient Representative Program designed to fill a recognized communications gap with patients and visitors and to provide a mechanism for expeditious resolution of patient problems was established. University Hospitals has also initiated an aggressive capital replacement program targeted at creating a modern therapeutic-educational environment for Iowa patients which is pleasant, functional and coordinate with present-day public expectations.

A third area of dramatic change is reflected in the multiplication of numbers of students and health science education programs being conducted at all levels in teaching hospitals. In 1970, University Hospitals served as the clini-

cal training base for 1,590 students in 20 health science educational programs. By 1980, this commitment had expanded to 2,228 students in 35 programs, representing only one teaching hospital's experience with the explosion in growth of its health science education mission.

What can Iowa practitioners contribute to the effectiveness of their own major teaching resource, University of Iowa Hospitals and Clinics?

Iowa's community physicians, in collaboration with the clinical staff of the University of Iowa Hospitals and Clinics, have created a medical care delivery system in this state in which all Iowans may take pride. The common trust inherent in the longstanding relationship between Iowa physicians and this center has made possible the development of a quality comprehensive tertiary center at the University Hospitals to support the natural stratification of health care delivery in Iowa. Our first priority for the future must be to sustain this trust which has nurtured for this state an enviable record of quality patient care.

IN 1981, UNIVERSITY HOSPITALS WILL . . . Continue direction of the Statewide Perinatal Care Program, whose educational and specialized care programs have helped bring a 49% decline in the neonatal mortality rate in Iowa since 1972 . . . Provide computerized ECG analysis services to Iowa hospitals by telephone . . . Continue to provide the services of the Air-Care emergency helicopter, which has transported nearly 1,200 patients since April, 1979.

These strong relationships are also reflected in the success of the statewide patient care and educational networks which have made it possible to decentralize and extend the expertise of our state's tertiary care referral center throughout Iowa. The participation and cooperation of Iowa physicians has been vital to the growth and refinement of the University Health Center's outreach programs. The Statewide Perinatal Care program, the Statewide Renal Dialysis and Transplantation Network, the Statewide Epidemiology Education and Consultation Program, the Statewide

Emergency Medical Services Network, the Iowa State Services for Crippled Children Program, Iowa's Childhood Cancer Diagnostic and Treatment Network, and a host of similar programs will continue to rely on the collaboration and support of Iowa physicians to

IN 1981, UNIVERSITY HOSPITALS WILL . . . Continue services for some 330 persons receiving care at Iowa's Satellite and Center Renal Dialysis Facilities and about 80 patients who will have kidney transplants at the Transplantation Center . . . Coordinate the Childhood Cancer Program that allows some 270 pediatric cancer patients to receive the bulk of their care from 102 participating community physicians . . . Provide services of the Mobile Critical Care Unit, which transports 15 to 30 infants, children, and adults per month to University Hospitals' intensive care units.

ensure that these services extend optimal benefits to Iowans.

This same complementary rapport has supported the University Health Center as it strives to fulfill its educational responsibilities. Cooperative efforts to meet the state's need for

primary care physicians have led to the creation of family practice training programs in 8 community hospitals outside the immediate Iowa City area. With the support of Iowa physicians, many additional hospitals sponsor rotations for resident physicians in a broad array of medical specialties. The mutual commitment of Iowa doctors and this center to education has resulted in a steady improvement in the number and geographic distribution of physicians throughout Iowa.

The Reagan administration is now considering a number of initiatives to decentralize health planning and policy formulation. These initiatives will bring new opportunities for us to nourish and strengthen the rapport which our long history of voluntary cooperation has established. In the upcoming era, community physicians can play an important part in interpreting the tripartite service-education and research role of their tertiary care center to local health planners and policymakers. Tomorrow's challenges will be met only by sustaining the traditional mutual understanding, trust and support that has existed between this center and Iowa physicians and which has served Iowans so successfully in the past.

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VOX DOCS

Please take a look at this month's Vox Docs question. It's below! Give us your opinion. Send it to IMS JOURNAL, 1001 Grand Avenue, West Des Moines, Iowa 50265. Last month's question and answer results are shown to the right with several of the comments we received printed below.

"The patient must be educated to accept, however!" — M. H. Dubansky, M.D., Des Moines

"Okay. With adequate safeguards and pre-op evaluation! Less hospital acquired infection. Less expensive. Less frightening." — H. S. Jacobi, M.D., Waterloo

"This is cost effective and puts more responsibility on the family to care for the patient and does not compromise quality care in routine cases." — M. N. Williams, M.D., Cedar Falls

"This concept is long overdue. Third-party payment has prevented us from developing this kind of service. Hospital administrators must bear responsibility for making this concept marketable. I will predict physicians will adjust to the concept in direct proportion to the ease with which the hospitals will make it possible." — S. W. Greenwald, M.D., Iowa City

LAST MONTH'S QUESTION —

A listing of procedures suggested for outpatient/same-day surgery have been distributed by the Iowa Foundation for Medical Care. How do you feel about the current emphasis on performing surgical procedures on this basis?

THINK IT'S A GOOD IDEA	81%
THINK IT'S A BAD IDEA	5%
NO STRONG OPINION	14%

"It may well result in savings both in time and medical costs so long as it is not a mandatory program. It is important that it be accepted as an educational program and tried so physicians and patients both can learn there is no increase in risk. I am certain there are some procedures on the list that will not lend themselves to routine one-day surgery. They can be weeded out relatively early." — K. E. Lister, M.D., Ottumwa

"Children especially benefit from the shortened time away from home, tending to leave in their minds less fear and sense of abandonment by family members." — R. T. Soper, M.D., Iowa City

APRIL QUESTION FOR IOWA PHYSICIANS

Malpractice claims are frequently attributed to poor doctor/patient communications. Reflecting on your own practice and others you observe, what level of importance do you think is assigned by physicians to patient communications?

- ☐ VERY HIGH
☐ FAIRLY HIGH
☐ COULD BE MUCH HIGHER

Comment, please _____

Name _____

Address _____

(Please Complete & Send to IMS JOURNAL, 1001 Grand Avenue, West Des Moines, Iowa 50265)

OUTPATIENT SURGERY —



Balancing Costs and Medical Necessity

Some 21 million inpatient surgical procedures are performed annually in the United States at a cost of more than \$300 billion. In Iowa, the average inpatient hospital stay costs more than \$1,400.

That's why Blue Cross and Blue Shield of Iowa support ambulatory surgery programs as a means to significantly reduce the cost of health care in our state, where hospital utilization ranks among the highest in the nation.

In addition to cost savings, same-day surgery provides convenience to both patients and physicians and reduces apprehension for patients facing hospitalization. Quality care is maintained and the benefits of recovery and recuperation in the home mean less time away from family and work.

The Iowa Foundation for Medical Care (IFMC), with input from the Iowa Medical Society and Blue Cross and Blue Shield of Iowa have developed a list of procedures that can be safely performed in an outpatient setting.

We encourage physicians to familiarize themselves and their patients with the IFMC's list and seek outpatient arrangements whenever appropriate.



**Blue Cross
Blue Shield**
of Iowa

Toxic-Shock Syndrome In Iowa

ROBERT L. PINSKY, M.D.,
CHARLES M. HELMS, M.D., Ph.D.,
LEE ROBAK, M.D.,
JOELLEN HOTH, M.D.,
A. PATRICK SCHNEIDER, II, M.D., and
LAVERNE A. WINTERMEYER, M.D.

TOXIC-SHOCK SYNDROME (TSS) is a recently described acute febrile illness occurring most frequently in young women at the time of menstruation.¹⁻⁵ The syndrome is often serious and fatalities have occurred. Epidemiological associations of TSS with tampon usage and with isolation of *Staphylococcus aureus* from the vagina or cervix have been made.^{4, 5} In this article we present 2 illustrative case histories, discuss the present state of knowledge of this Syndrome, and summarize the experience with TSS in Iowa.

CASE 1

A previously healthy 20-year-old mother of one was hospitalized at Burlington Medical Center in October, 1976 after 2 days of

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Thirty confirmed and 9 probable cases of Toxic-Shock Syndrome have been reported to the State Department of Health. These cases are among Iowa females ages 14 to 41 residing in 21 counties. Two episodes of TSS are described. Etiology and treatment are summarized.

headache, weakness, intense myalgia, vomiting and diarrhea. On admission she appeared acutely ill, weak, lethargic and dehydrated. The temperature was 38°C and blood pressure 80/40 mmHg. Stomatitis and pharyngitis were present. The patient was menstruating. The peripheral white blood cell (WBC) count was 23,100/mm³ with a marked left shift. The chest radiograph was normal. Intravenous fluids were administered and parenteral penicillin therapy was begun after a throat culture was obtained.

Shortly thereafter she complained of chest pain and dyspnea. The temperature rose to 39°C and she became disoriented. A lung scan was not diagnostic and the electrocardiogram revealed sinus tachycardia only. Cerebrospinal fluid analysis was normal. Blood cultures were obtained, penicillin was discontinued and intravenous ampicillin was begun.

Oliguria was noted on the second hospital day. The blood urea nitrogen (BUN) was 43 mg/dL, serum creatinine 8.9 mg/dL and the

THE SCANLON MEDICAL FOUNDATION/IOWA MEDICAL SOCIETY HAS DESIGNATED THIS ARTICLE
AS THE HENRY ALBERT SCIENTIFIC PRESENTATION FOR THE MONTH OF APRIL 1981.

TABLE 1
TOXIC-SHOCK SYNDROME CASE DEFINITION*

1. Fever (temperature ≥ 38.9 C [102 F]).
2. Rash (diffuse macular erythroderma).
3. Desquamation, 1-2 weeks after onset of illness, particularly of palms and soles.
4. Hypotension (systolic blood pressure ≤ 90 mm Hg. for adults or < 5 th percentile by age for children < 16 years of age, or orthostatic syncope).
5. Involvement of 3 or more of the following organ systems:
 - A. Gastrointestinal (vomiting or diarrhea at onset of illness).
 - B. Muscular (Severe myalgia or creatinine phosphokinase level $\geq 2 \times$ ULN†).
 - C. Mucous membrane (vaginal, oropharyngeal, or conjunctival hyperemia).
 - D. Renal (BUN‡ or Cr§ $\geq 2 \times$ ULN or ≥ 5 white blood cells per high-power field — in the absence of a urinary tract infection).
 - E. Hepatic (total bilirubin, SGOT^{||}, or SGPT[#] $\geq 2 \times$ ULN).
 - F. Hematologic (platelets $\leq 100,000/\text{mm}^3$).
 - G. Central nervous system (disorientation or alterations in consciousness without focal neurologic signs when fever and hypotension are absent).
6. Negative results on the following tests, if obtained:
 - A. Blood, throat, or cerebrospinal fluid cultures.
 - B. Serologic tests for Rocky Mountain spotted fever, leptospirosis, or measles.

* From *Morbidity and Mortality Weekly Report* 29:442, 1980.

† Twice upper limits of normal for laboratory.

‡ Blood urea nitrogen level.

§ Creatinine level.

^{||} Serum glutamic oxaloacetic transaminase level.

[#] Serum glutamic pyruvic transaminase level.

creatinine phosphokinase (CPK) level was greater than 1000 IU/L. Rhabdomyolysis was suspected. The serum bilirubin was 5.4 mg/dL. A pelvic examination revealed severe vaginitis and a foul-smelling tampon was removed. Suspecting possible anaerobic pelvic sepsis, ampicillin was discontinued and chloramphenicol begun. Intravenous fluids were increased with a resultant normalization of blood pressure and urine output. Chloramphenicol therapy was stopped after 5 doses when the platelet count was noted to be $80,000/\text{mm}^3$.

After the third hospital day she improved steadily. Hematological and chemical abnormalities corrected by the sixth hospital day. A diffuse macular erythematous rash developed which resolved without specific therapy. Marked desquamation of the palms and soles followed during convalescence. Cultures of throat, stool, blood and cerebrospinal fluid grew no pathogens. A vaginal swab culture grew *Staphylococcus aureus* and *Escherichia coli*. She was discharged 10 days after onset of symptoms.

Comment: This case meets all criteria estab-

lished for the diagnosis of TSS which are summarized in the Table. For reporting purposes, the case is referred to as a confirmed case.

The clinical features of this and other confirmed cases are strikingly similar. Illness begins characteristically a few days after onset of menstruation with abrupt onset of fever, myalgia, headache, and sore throat. Nausea, vomiting and watery diarrhea follow rapidly, often leading to marked volume depletion and hypotension. Conjunctival or pharyngeal injection, a "strawberry" tongue, and a scarlatiniform rash are often present within one to two days of onset. Peeling of the skin of the palms and soles occurs one to two weeks after onset of symptoms. In severe cases, shock, alterations of consciousness, renal failure and respiratory distress syndrome have posed management problems. Laboratory features often include leukocytosis with a marked left shift, early thrombocytopenia, elevated CPK enzyme levels with or without evidence of rhabdomyolysis, elevated serum parenchymal liver enzyme (GOT, GPT) levels, hyperbilirubinemia, hypocalcemia and hypoalbuminemia. In over 75% of cases *S. aureus* has been isolated from the vagina or cervix. Diagnosis depends on recognition of the syndrome and exclusion of gram-negative sepsis, scarlet fever, and other bacterial, rickettsial and viral infections.

CASE 2

A previously healthy 19-year-old homemaker was referred to University Hospitals in March, 1979 after one day of fever, chills, headache, myalgia, nausea, vomiting, and progressive lethargy. She was 3 months postpartum and nearing the end of her first menstrual period since delivery. The admission temperature was 40°C , heart rate 160 per minute and blood pressure 108 mmHg systolic. She was obtunded with nuchal rigidity. A brownish purulent discharge covered a retained vaginal tampon. The remainder of the examination was unremarkable. The WBC count was $20,800/\text{mm}^3$ with a marked predominance of granulocyte precursors. Prothrombin and partial thromboplastin times were slightly prolonged, but the platelet count and fibrinogen level were normal. Abnormal blood chemistry determinations noted were GOT 54 IU/L (normal 7.5-40.0), LDH 328 IU/L

(normal 100-225), CPK 872 IU/L (normal 35-150) all of skeletal muscle origin, and calcium 7.4 mg/dL (normal 8.5-10.5). A moderately severe metabolic acidosis, proteinuria and occult hematuria were present. The cerebrospinal fluid examination was normal.

Shortly after admission, the systolic blood pressure fell to 68 mmHg, but responded to intravenous fluids. Parenteral chloramphenicol and gentamicin were begun after cultures of blood, urine, cerebrospinal fluid and cervix were obtained. The cervical culture grew *Staphylococcus aureus*, but all other cultures were negative.

On the second hospital day, a patchy erythematous macular rash was noted on the anterior chest and face. Scattered petechiae were present in the axillae and on the soles. Conjunctival injection was also present. Fever resolved by the third hospital day, and all symptoms and laboratory abnormalities resolved over the following week. The hepatitis B surface antigen determination, fluorescent antinuclear antibody titer, rheumatoid factor titer, and heterophil, Brucella and Leptospira agglutinin titers were negative or unremarkable. She was discharged 10 days after the onset of symptoms.

Two days after discharge, she again experienced chills, fever to 40°C, headache, myalgia and stiff neck, and was hospitalized elsewhere. Her menstrual flow had ceased two days previously. Bilateral conjunctival injection was still present and 2 purulent ulcerated lesions of the cervix were noted. The WBC count was 44,000/mm³ with a left shift. Biopsy of the cervical lesions revealed necrotic tissue and cultures again grew *Staphylococcus aureus*. Cerebrospinal fluid again was normal and cultures of blood, urine, and cerebrospinal fluid were sterile. By the second hospital day following intravenous fluids she was afebrile and asymptomatic. The WBC count normalized and she was discharged 4 days after admission.

Comment: This case was recognized retrospectively in July, 1980 as a case of TSS-like illness. A phone call to the patient established that she had done well since hospitalization, and, interestingly, that no desquamation had occurred. Strictly speaking, then, all criteria for the diagnosis of TSS were not met in this case. We have classified this and similar cases which

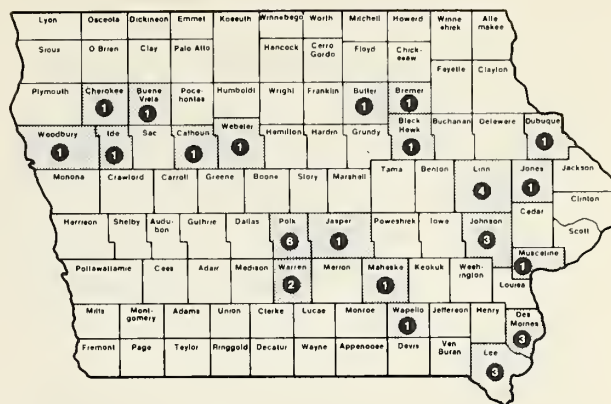


FIGURE 1 — Distribution of confirmed and probable Iowa TSS cases by county of residence.

meet 5 of the 6 diagnostic criteria as probable TSS cases.

One or more recurrences of TSS have occurred in about 25% of cases. The great majority of recurrences have been in association with menstrual bleeding and tampon use. Recurrence of TSS intermenstrually is an unusual feature of this case.

DISCUSSION

Over 941 confirmed cases of TSS have been reported to the Centers for Disease Control since 1970. Nine hundred-five of these cases were in menstruating women. The case-fatality ratio has been 7.8%.⁶ As of January 31, 1981, 30 confirmed and 9 probable TSS cases in women 14 to 41 years of age have been reported to the State Department of Health. The earliest confirmed case in a resident reported thus far (Case 1) occurred in October, 1976. One death in a probable case has occurred for a case-fatality ratio among confirmed and probable cases of 2.6%.

Thirty-six of the confirmed and probable cases occurred in residents of Iowa; three probable cases were from out-of-state. The Iowans lived in 21 counties, indicating wide-spread geographic distribution of TSS (Figure 1).

Twenty-four confirmed and four probable cases occurred in residents between January 1, 1980 and December 31, 1980 for an estimated annual incidence in Iowa of 3.3/100,000 women in the menstruating age group (10-49 years). This is undoubtedly an underestimate of the incidence since TSS has not been a reportable disease.

All cases occurred in women who used tampons for menstrual hygiene. Rely™ tampons were used by 20 (51%), other brands by 13 (33%) and unknown brands by 6 (16%). The high frequency of Rely™ tampon use in these cases is consistent with recent reports relating use of Rely™ with increased risk of TSS.^{7, 8} Without an appropriate control group, however, a statistically valid linking of Rely™ tampons cannot be made. An ongoing cooperative epidemiologic study (Tri-State TSS Study) between the states of Minnesota, Wisconsin and Iowa may clarify this relationship.

The etiology of TSS is unclear. Preliminary studies have shown a disproportionately high rate of recovery of *Staphylococcus aureus* from vaginal and cervical cultures from affected women.^{4, 5, 7} While in the illustrative cases, obvious vaginal and cervical lesions were described, in many cases *S. aureus* has been isolated from women without genital lesions. A pathogenic role for a staphylococcal toxin has been postulated,¹ but this hypothesis requires further study.

TSS should be considered in the differential diagnosis of any febrile illness with vomiting and diarrhea in a menstruating woman using tampons. The presence of rash, leukocytosis with a left shift and *S. aureus* in the vagina or cervix should strengthen clinical suspicion.

TREATMENT

Treatment at this stage in our knowledge of TSS involves: 1) removal of retained tampons; 2) aggressive supportive measures, particularly adequate fluid and electrolyte replacement; and 3) anti-staphylococcal therapy. Discontinuation of tampon usage appears to prevent recurrences in most cases. In addition, treatment with beta-lactamase resistant antibiotics may also decrease the risk of recurrence.⁴ A 7 to 10 day course of anti-staphylococcal antibiotic therapy appears prudent at this time, especially if *Staphylococcus aureus* is recovered from vaginal, cervical, throat, nasal, or other cultures.

The Iowa State Department of Health is investigating TSS cases in Iowa. Potential TSS cases should be reported to Laverne Wintermeyer, M.D., Iowa State Department of Health, Des Moines (515-281-5643) or Charles Helms, M.D. Department of Internal Medicine, University of Iowa Hospitals and Clinics, Iowa City (319-356-1773).

ACKNOWLEDGMENTS

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Infection Morbidity After Cesarean Section

MICHAEL W. VARNER, M.D., and

RUDOLPH P. GALASK, M.D.

Iowa City, Iowa

DURING THE LAST DECADE the incidence of cesarean section has increased dramatically. Many of these procedures are performed during labor because of fetal indications, to avoid birth trauma or to rescue an asphyxiated fetus. Although an increased cesarean section rate has been associated with an improved perinatal survival rate, it has also increased the frequency of maternal postoperative infection. The reported incidence of post-primary cesarean section endometritis ranges between 29%⁹ and 85%,¹ which is 5 to 15 times the rate observed in similar populations delivered vaginally. This variation in reported rates of infections not only emphasizes differences between patient populations, but also complicates any review of the literature on post-cesarean section infections. The prevalence of infection complications is commonly believed to be less in areas where high levels of maternal nutrition and relatively homogeneous populations exist, while the incidence of infection complications is higher in urban minority groups. It is important to be mindful of these differences when reading the literature and when dealing with specific patient populations.

MICROBIOLOGY

The majority of obstetric infections involve organisms endogenous to the reproductive tract. This microbial population changes

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A high incidence of maternal postoperative infection follows primary cesarean section. Many of the infections involve more than one bacterial species. Treatment of post-cesarean section endometritis should begin with broad spectrum antibiotics. The further aspects of treatment are described here.

through the course of pregnancy, with a decline in the number of isolatable species per patient. This decrease involves both aerobic and anaerobic organisms.⁵ A significant finding is the increase in number of species, especially of anaerobes, in the early postpartum period. It has been suggested this change may be due to the withdrawal of hormonal support as well as the presence of lochia and necrotic decidua.⁵

A major problem in evaluating obstetric infections has been the difficulty in obtaining satisfactory culture material. A number of techniques have been used, most of which are similar. However, when obtaining material for culturing obligate anaerobes, a specimen of tissue (ex. decidua, abscess contents in a syringe) is preferable. Anaerobic microbiology can be complicated and expensive. Therefore, knowledge of the most probable organisms and their susceptibilities can be helpful in selecting the appropriate antibiotic therapy, especially when therapy must be started on empiric grounds. The Gram stain can also be helpful, although obstetric infections are frequently polymicrobial in nature. Because of this it may be difficult to isolate a predominant organism on the basis of the Gram stain alone.

The most commonly isolated organisms from patients with endometritis at University

of Iowa Hospitals are the aerobic and anerobic streptococci, which are found in approximately 70% of transcervically obtained cultures. Over 50% of patients are also found to have aerobic Gram negative rods, the most common of which is *Escherichia coli*. The anaerobic Gram negative rods, which include *Bacteroides fragilis*, represent the third group with significant virulence.

Clostridium perfringens is not frequently isolated and when cultured from an otherwise healthy individual is of little clinical significance. However, it may cause a life-threatening infection with septicemia, shock, hemolysis, and renal failure. This problem is more likely to appear following at least 24 hours of incubation in the presence of devitalized tissue. The treatment of choice is surgical debridement and antibiotics. The drug of choice is penicillin and most infections respond to ampicillin or a cephalosporin as well. However, it is important to carefully monitor the blood pressure, pulse, and urinary output in these patients to avoid major sequelae.

Infections in postpartum patients are likely to be polymicrobial, frequently with bacteremia as well. Wound infections and endometritis often represent the same organisms found in the upper vagina and endocervix at the time of cesarean section. This supports the hypothesis that ascending colonization by organisms from the lower genital tract of surgically traumatized tissue results in the observed polymicrobial pelvic infections. A similar ascending microbiologic flora is also found in other female genital infections, including septic abortions, pelvic inflammatory disease, and post-hysterectomy cuff infections.

FACTORS & ETIOLOGY

One of the largest and certainly most obvious factors in post-cesarean section infection morbidity is the surgical trauma itself. Given two similar patient populations in labor with positive amniotic fluid cultures, the abdominally delivered patients will have a 5-15 fold greater infection rate.^{1, 9} A reasonable interpretation of this combination of findings is that normal maternal defenses allow the majority of vaginally delivered patients to clear the organisms prior to gross clinical infection. However, in the abdominally delivered patient these defenses have been disturbed, by surgical invasion of the myometrium, by the placement of a

foreign body (suture) in the myometrium, and by the increased possibility of hematoma formation.

Several recent studies have investigated factors which predispose patients to post-cesarean section infection.^{2, 4, 7} The most consistent findings are labor prior to cesarean section, ruptured membranes prior to cesarean section, and multiple vaginal examinations in labor. Internal fetal monitoring has also been implicated, as has anemia (and/or the requirement for transfusion), and the urgency and duration of the operation. Other factors which have been reported, but not universally accepted, include obesity, use of general anesthesia, advanced maternal age, socioeconomic status (possibly a reflection of maternal nutrition), race (more common in blacks), and the presence of neutrophils or bacteria in the amniotic fluid.

Internal fetal monitoring has been implicated as a cause of ascending infection, although it is only used in patients who are already in labor with ruptured membranes and who are receiving vaginal examinations. Studies have documented increased bacterial contamination of the amniotic fluid within one hour after insertion of internal monitors.¹⁰ However, two prospective studies have suggested that internal fetal monitoring adds no additional risk beyond that already associated with labor, ruptured membranes, and multiple vaginal examinations.^{3, 8} Until this controversy is resolved, the obstetric service at University of Iowa Hospitals will continue to use internal fetal monitoring when clinically appropriate.

TREATMENT

Prior to initiating treatment of post-cesarean section endometritis the physician must be certain of the diagnosis. There are also non-infectious causes of febrile morbidity, including dehydration, atelectasis, drug fever, collagen vascular diseases, sickle crises, tumors, and factitious fever. Fever may also result from non-genital infections, most commonly urinary tract infections. Wound infections are also common and usually develop several days after delivery. Less common non-genital infections include pneumonia, mastitis, complications of regional anesthesia, phlebitis, and soft-tissue infections.

In treatment of any pelvic infection several

general supportive measures can be helpful: 1) semi-Fowler's position may help to confine serious infections to the pelvis; 2) assurance of adequate uterine drainage; 3) adequate hydration of the patient, and 4) careful attention to intake and output as well as renal and gastrointestinal tract function.

If antibiotics are to be used, cultures, with sensitivities, should be obtained whenever possible. Cultures should be obtained from all clinically suspected sites. Blood cultures should also be included in this evaluation since bacteremia is more common in pregnancy and the immediate puerperium. Treatment should begin with broad spectrum antibiotics. Numerous regimens are reported in the literature, but any regimen should be based on the known epidemiologic factors of the specific hospital. At University Hospitals treatment is initiated with intravenous ampicillin or a cephalosporin. An aminoglycoside may be added depending on the clinical severity of the infection. These drugs are chosen because of the relative predominance of streptococcal organisms and Gram negative rods. Clindamycin and chloramphenicol are reserved for severe, life-threatening infections. These antibiotics are also particularly effective against anaerobic organisms. It is important to continue treatment for at least 4 or 5 days after resolution of symptoms. Parenteral therapy should be continued for 24 to 48 hours after the patient becomes afebrile and for 4 or 5 days if blood cultures are positive. It should be emphasized that patient therapy should also include clinical judgment. If the patient is improving, even though the sensitivity suggests otherwise, the plan of management should not be altered.

The most common reasons for failure of antibiotic therapy are: 1) abscess formation, 2) a resistant organism, and, 3) septic pelvic thrombophlebitis.

The most common example of a resistant organism is infection due to *Bacteroides fragilis* resistant to penicillins, cephalosporins, and aminoglycosides. The drug of choice is clindamycin, but cefoxitin or chloramphenicol are reasonable alternatives.

Abscess formation usually develops later in the postoperative course. On examination larger abscesses can be palpated, but voluntary guarding or incisional pain may make this diagnosis difficult. The abscess may point to the groin, cul-de-sac, or wound, and be drained

directly. Unfortunately, they are not always amenable to drainage by these routes and may require laparotomy and occasionally extirpation of the pelvic organs. These latter unfortunate outcomes are more common in patients who undergo unnecessary or inappropriate classical cesarean section.¹¹

The characteristic appearance of a patient with septic pelvic thrombophlebitis is that of a woman who appears well, with at most minimal or poorly localized pain despite a spiking temperature. Abdominal findings are usually minimal and pelvic findings often consist of no more than vague tenderness laterally or high in the pelvis. Usually the patient will defervesce within 24-48 hours after initiating heparin therapy. When blood cultures are positive appropriate antibiotics should be continued.

ANTIBIOTIC PROPHYLAXIS

Although studied in other fields since the early years of antibiotic availability, the subject of prophylactic antibiotics for patients undergoing cesarean section was first studied only in the late 1960's. By definition, antibiotic prophylaxis involves the use of antibiotics to prevent infection where contamination might occur, but is not yet present.

Cesarean section is a procedure with a low mortality, but with a high infection morbidity rate. As previously mentioned, 29%⁹ to 85%¹ of those patients undergoing primary cesarean sections, following a trial of labor and who receive no prophylaxis, will experience some type of febrile morbidity. Most will have pelvic or wound infections. In the majority of studies there appears to be some benefit from prophylactic antibiotic administration, with reduction in febrile morbidity and pelvic or wound infections.

As mentioned previously, bacteria found in cultures of pelvic and wound infections after cesarean section are similar to those found in cultures of the endocervix at term. It is not necessary to use a prophylactic antibiotic regimen effective against all the potential pathogens present. A number of different antibiotic regimens have been tried, all with some success. Any agent selected for prophylaxis should be safe, well tolerated, and not a first line drug for the treatment of serious infections. Cephalosporins are employed for antibiotic prophylaxis in primary cesarean sections at University Hospitals.

The method of drug administration is as important as the choice of drugs. To be truly prophylactic, and not therapeutic, the antibiotic should be given parenterally, in high doses, and for a short time, usually no more than 12 hours beyond surgery. The general principles of surgical antibiotic prophylaxis require that tissue levels of antibiotics should be achieved before the time of incision. However, it has recently been shown equally effective to give the first IV dose to the mother as soon as the cord is clamped⁶ and this approach is currently followed at University Hospitals. This avoids giving antibiotics to the newborn.

It has also been demonstrated that short term prophylaxis does not delay the diagnosis of postpartum infection.⁶

The risk of infection following repeat cesarean section is considerably lower than that following primary cesarean section, probably due to the elective nature of the procedure and the absence of risk factors such as labor or ruptured membranes. The routine use of prophylactic antibiotics to prevent infection following repeat cesarean section is therefore not warranted in most obstetric populations.

There are also potential disadvantages of prophylactic antibiotics with primary cesarean section that require discussion. These include: 1) Changes in the normal flora of the patient with selection of organisms that are not sensitive to the antibiotics being administered. In this setting, the potential for antibiotic resistant infections exists. 2) Concern regarding masking infection during hospitalization has been expressed, although this has not been documented with truly prophylactic antibiotic usage. 3) The principles of sterile technique may be relaxed when prophylaxis is used. 4) Allergic reactions and non-allergic toxicity may occur. 5) Additional cost of the drug as well as the cost of drug related complications should be recognized.

At present, the decision to use prophylactic antibiotics for primary cesarean section must be based on evaluation of these risk factors against the overall risk of infection in a specific population. This risk can be best estimated by an ongoing infection surveillance program within each hospital.

The following represents current guidelines for prophylactic antibiotic usage and can be applied to both obstetrics and gynecology:

1. The procedure must have a significant postoperative infection morbidity, or the patient thought to have an altered host response to infection.

2. The operative procedure must be associated with a high probability of microbial contamination.

3. The drug must be of low toxicity, have an established record of patient safety, and not be routinely utilized for serious infections.

4. The drug must have a spectrum of activity that includes those microorganisms from the site of contamination that are most likely to cause infection.

5. The drug must achieve a reasonable tissue concentration prior to the procedure (at the time of cord clamping may be equally efficacious in cesarean section) and be administered for a short duration.

6. The hospital must have a functioning infection surveillance program that has established guidelines and maintains current antibiotic susceptibility patterns before beginning elective prophylaxis.

CONCLUSION

Primary cesarean sections are associated with a high incidence of maternal postoperative infections. The majority of these infections involve organisms endogenous to the female reproductive tract, the most common of which are the aerobic and anaerobic streptococci, followed by the aerobic and anaerobic Gram negative rods. Many of these infections involve more than one bacterial species and bacteremia is more common than in the non-pregnant woman.

Treatment of post-cesarean section endometritis should begin with broad spectrum antibiotics, such as an intravenous penicillin or cephalosporin. Aminoglycosides are added as a second drug while antibiotics with particular anaerobic effectiveness are commonly reserved for severe or resistant infections.

Antibiotic prophylaxis has been shown to reduce infection morbidity following primary cesarean section. The antibiotic should be given parenterally and for a short duration. Administration of the drug at the time of cord clamping may be as effective as administering the drug prior to the procedure.

REFERENCES

The references noted in this paper are available on request either from the authors or the JOURNAL OF THE IOWA MEDICAL SOCIETY.



COMMENTING EDITORIALLY

MARION E. ALBERTS, M.D.
SCIENTIFIC EDITOR

ANNUAL UNIVERSITY ISSUE

It is our custom and pleasure to dedicate this issue of the JOURNAL to the University of Iowa College of Medicine. This year's University

1981 HOUSE OF DELEGATES

Just a word about the Iowa Medical Society House of Delegates which meets May 2 and 3 in Des Moines! We talk frequently about wanting to have our say. Here is your chance! This is the annual occasion when Iowa medicine's representative form of government performs.

Issue features comments from Dean John W. Eckstein on the U. of I. Clinical Research Center and his concern for its survival. Challenges of the 1980's at the University of Iowa Hospitals and Clinics are provided by Director, John W. Colloton. Certainly apparent in their combined remarks is the broad dedication to excellence which exists at the College of Medicine and University Hospitals. The Iowa medical profession can be proud to have institutions of this caliber available to serve the needs of the profession and its patients.

The JOURNAL has been provided many excellent scientific papers by faculty authors and we appreciate the opportunity to publish this material. Also appreciated is the monthly effort by Richard M. Caplan, M.D., author of the JOURNAL feature, OUR MAN ON EDUCATION. — M.E.A.

If you are one of the 223 physician delegates to the 1981 House, you have a responsibility to represent your county medical society. It should be a busy two-day period as already there are 20 or so resolutions set for introduction.

The House of Delegates influences mightily the medical care direction in Iowa. It is an important exercise.

Letter to the Editor

ENOUGH ALREADY

Dear Editor:

It would seem that the time has come for us to say to our pharmacist "friends": "Enough, already!"

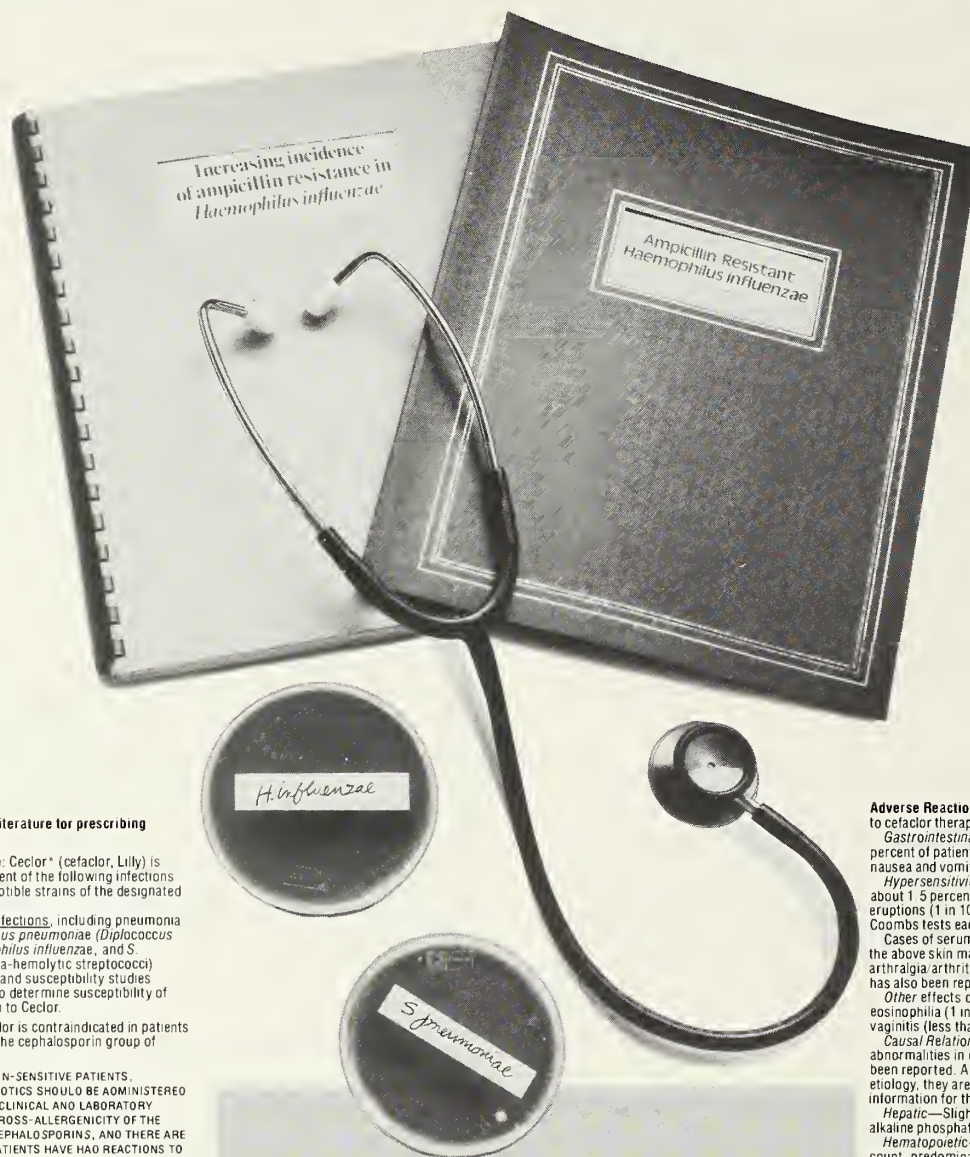
Through the years we have acceded to their suggestions and demands until we have "cooperated" away many of those responsibilities and privileges which traditionally have belonged to the physician. It has never been quite clear how dispensing from a physician's

office is unethical except that, by prodding from the pharmacists, it has been so declared. It cannot be a question of professional competence since a physician — or his trusted assistant — can count capsules or measure liquids as accurately as anyone else.

It has even been suggested — apparently seriously — that the physician submit his diagnosis to the pharmacist who then will assume the task of prescribing for the patient. Some changes in the law will be required if the "task" becomes a legal responsibility should something go wrong. The pharmacist's so-called expertise regarding medications is pretty well limited to what he reads in the PDR and the package inserts, and hears in the exhorta-

(Please turn to page 159)

An added complication... in the treatment of bacterial bronchitis*



Brief Summary. Consult the package literature for prescribing information.

Indications and Usage: Cefclor* (cefaclor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms:

Lower respiratory infections, including pneumonia caused by *Streptococcus pneumoniae* (*Diplococcus pneumoniae*), *Haemophilus influenzae*, and *S. pyogenes* (group A beta-hemolytic streptococci). Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Cefclor.

Contraindication: Cefclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS, AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS TO BOTH DRUG CLASSES (INCLUDING ANAPHYLAXIS AFTER PARENTERAL USE).

Antibiotics, including Cefclor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs.

Precautions: If an allergic reaction to cefaclor occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e.g., pressor amines, antihistamines, or corticosteroids.

Prolonged use of cefaclor may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs test may be due to the drug.

Cefclor should be administered with caution in the presence of markedly impaired renal function. Under such a condition, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended.

As a result of administration of Cefclor, a false-positive reaction for glucose in the urine may occur. This has been observed with Benedict's and Fehling's solutions and also with Clinistest® tablets but not with Tes-Tape® (Glucose Enzymatic Test Strip, USP, Lilly).

Usage in Pregnancy: Although no teratogenic or antifertility effects were seen in reproduction studies in mice and rats receiving up to 12 times the maximum human dose or in ferrets given three times the maximum human dose, the safety of this drug for use in human pregnancy has not been established. The benefits of the drug in pregnant women should be weighed against a possible risk to the fetus.

Usage in Infancy: Safety of this product for use in infants less than one month of age has not been established.

Some ampicillin-resistant strains of *Haemophilus influenzae*—a recognized complication of bacterial bronchitis*—are sensitive to treatment with Cefclor.¹⁻⁶

In clinical trials, patients with bacterial bronchitis due to susceptible strains of *Streptococcus pneumoniae*, *H. influenzae*, *S. pyogenes* (group A beta-hemolytic streptococci), or multiple organisms achieved a satisfactory clinical response with Cefclor.⁷

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cefaclor

Pulvules®, 250 and 500 mg

Adverse Reactions: Adverse effects considered related to cefaclor therapy are uncommon and are listed below: *Gastrointestinal* symptoms occur in about 2.5 percent of patients and include diarrhea (1 in 70) and nausea and vomiting (1 in 90).

Hypersensitivity reactions have been reported in about 1.5 percent of patients and include morbilliform eruptions (1 in 100). Pruritus, urticaria, and positive Coombs tests each occur in less than 1 in 200 patients. Cases of serum-sickness-like reactions, including the above skin manifestations, fever, and arthralgia/arthritis, have been reported. Anaphylaxis has also been reported.

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients).

Causal Relationship Uncertain—Transitory abnormalities in clinical laboratory test results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician.

Hepatic—Slight elevations in SGOT, SGPT, or alkaline phosphatase values (1 in 40).

Hematopoietic—Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40).

Renal—Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200).

[103080R]

*Many authorities attribute acute infectious exacerbation of chronic bronchitis to either *S. pneumoniae* or *H. influenzae*.

Note: Cefclor* (cefaclor) is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

References

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Additional information available to the profession on request from Eli Lilly and Company, Indianapolis, Indiana 46285.

Eli Lilly Industries, Inc. Carolina, Puerto Rico 00630

100061

tions of detail men. Somebody has to watch the patient because things don't always come out as the detail man says they will.

Then there is that process whereby the customer presents himself in the drugstore and recites his diagnosis. Guided by this evaluation, the pharmacist reaches up on a shelf somewhere and presses upon the customer a preparation which is purported to be the remedy for his distress. This is known as counter prescribing. The fact that it was long ago declared unethical has not seriously inhibited the practice.

Now the Iowa pharmacists wish to intrude further between the physician and his patient. They are fostering a law which will forbid the doctor to instruct a trusted assistant to hand a patient some medication prescribed by the physician. This round-about attack upon physician dispensing is to be administered by the Board of Pharmacy Examiners. Medicine has its own legally constituted Board whose function is to monitor and supervise all aspects of medical practice in Iowa — including prescribing.

If this officious interference in patient care is permitted by the legislature, those other practices which extend the hands of the physician may likewise be forbidden. The doctor may then have to change the dressing on every cut finger, draw every sample of blood, take every temperature, and do all those other things which now can be done by less skilled hands. He may even have to clear it with the Board of Barber Examiners before he can ask an assistant to shave the hair from around a wound that must be sutured.

Everybody wants to be a doctor and direct the practice of medicine. There is only one way to become a physician: successfully contend with the curriculum in a College of Medicine and the necessary post-graduate training. It cannot be done in a College of Pharmacy, a College of Nursing, a College of Hospital Administration, a training course for Physicians Assistants or Family Nurse Practitioners, or anywhere else but a College of Medicine. Those who wish to intrude between the physician and his patient should remember this and direct their energies toward improving their performance in their chosen fields. — *James F. Bishop, M.D., Davenport*



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Appreciation to Physician Preceptors

THE UNIVERSITY OF IOWA College of Medicine extends sincere appreciation to the 180 Iowa physicians who served last year (7/1/79 to 6/30/80) as preceptors for third- and fourth-year medical students and for students in the Physi-

cian's Assistant Program. These preceptorships are an important element in the outreach effort of the college, and they permit students to observe first-hand a medical practice away from the academic setting.

1979-80 PRECEPTORS FOR THIRD YEAR PRECEPTORSHIP

Served Students from Class of 1981

Algona	Joy D. Mixdorf, M.D.
Ames	Howard H. Hildebrand, M.D., Poul G. Koellner, M.D., Walter W. Lorson, M.D., William C. McCormick, M.D., Jack T. Swanson, M.D.
Ankeny	Rodney R. Corlson, M.D.
Bloomfield	Mork D. Pobst, M.D. (2)
Boone	John F. Murphy, M.D. (3), Wayne E. Rouse, M.D.
Burlington	William E. Anderson, M.D., Donald R. McCabe, M.D. (2), A. Patrick Schneider, II, M.D., Joseph P. Stoikovic, M.D.
Cedar Falls	Robert N. Bremner, M.D., James R. Young, M.D. (4)
Cedar Rapids	James F. Stiles, M.D. (5), Robert L. Swoney, M.D. (4), Julianne Thomas, M.D. (3), Mork J. Tyler, M.D. (3), James H. Zisko, M.D.
Centerville	James B. McConville, M.D., Melvin G. Porks, M.D. (2)
Cherokee	Gene E. Michel, M.D.
Clorion	Charles P. Howkins, M.D.
Clinton	George L. York, M.D.
Corydon	Keith A. Gorber, M.D.
Council Bluffs	Ruben Altman, M.D., Dennis S. Jones, M.D., James Mulry, M.D.
Creston	Peter R. Morcellus, M.D.
Davenport	Borrry S. Borudin, M.D. (4), Atlee B. Hendricks, M.D. (2), Edwin A. Motto, M.D.
Decorah	James A. Bullard, M.D. (3)
Denison	Romoin L. Bendixen, M.D., Donald J. Soll, M.D.
Des Moines	James R. Bell, M.D., James L. Blessmon, M.D. (5), Richard R. Honkenson, M.D., Charles R. Peterson, M.D. (2), Ronald A. Shirk, D.O., Mork Thomon, M.D., John K. Uchiyomo, M.D., Chad Williams, M.D. (2)
Dubuque	John G. Brehm, M.D., John S. Chopmon, M.D., Eugene W. Coffmon, M.D., James R. Gilloon, M.D., Dorryl Mozeno, M.D.
Dyersville	Anthony J. Sweeney, M.D.

Figures in parentheses show number of students if more than one.

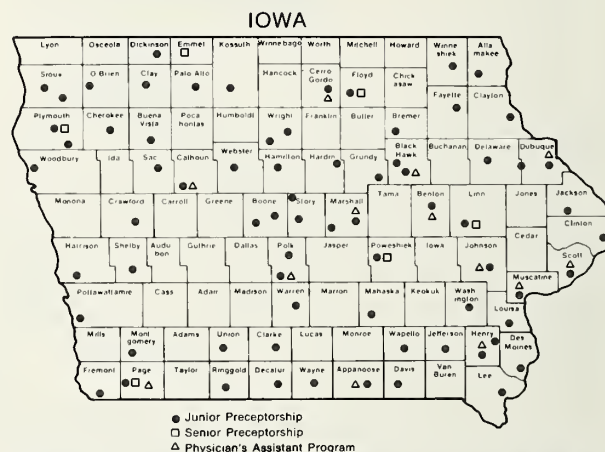


Figure 1 shows the community locations of physicians who served as preceptors for the three groups of students.

Eagle Grove	Dole A. Hording, M.D.
Emmetsburg	Corlyle C. Moore, M.D. (2), Gerold J. Wieneke, M.D.
Fairfield	James H. Dunlevy, M.D., Gene E. Egli, M.D. (4)
Fort Dodge	Richard H. Brondt, M.D.
Fort Madison	Glen A. Gabrielson, M.D.
Grinnell	Robert M. Corney, M.D., James P. Poulson, M.D., Bernhord G. Wiltfong, M.D. (3)
Guttenberg	Eugene M. Downey, M.D. (3), Robert J. Merrick, M.D. (2)
Hamburg	Frederic M. Ashler, M.D.
Harlon	Robert E. Donlin, M.D.
Indianola	Donald G. Flory, M.D.
Iowa City	Victor G. Edwards, M.D. (4), Nyle D. Kouffman, M.D. (3), Lorry G. Rigler, M.D., Thomas Rosenberger, M.D. (2), Mitchell C. Ruffcorn, M.D. (5)
Iowa Falls	Francis L. Pisney, M.D.
Kolono	Dwight G. Sottler, M.D. (7)
Kingsley	Charles Homm, M.D.

Loke City John W. Ely, M.D.
 Le Mors Doryl Doorenbos, M.D., James E. Powell, M.D.
 Leon Lorry W. Richord, M.D. (2)
 Monchester Mory Ann Arends, M.D. (2), Poul A. Seorles, D.O.,
 John E. Tyrrell, M.D.
 Moquoketo John A. Bromon, M.D. (2)
 Marshalltown David L. Thomas, M.D. (2), Milton J. Von Gundy,
 M.D. (3)
 Moson City John H. Brinkmon, M.D., Charles R. Coughlon,
 M.D. (2), Lorry R. Fone, M.D., W. Gene Gorrett,
 M.D., John C. Justin, M.D., David C. Little, M.D.,
 Curtis W. Nelson, M.D., George H. West, Jr.,
 M.D.
 Missouri Valley John M. Bornes, M.D.
 Mount Ayr Duane E. Mitchell, M.D.
 Mt. Pleasont Phillip G. Couchmon, M.D. (2), Warren B. Scott,
 M.D. (4)
 Muscotine Forrest D. Deon, M.D. (3), John J. Ellis, M.D. (3),
 John Fusselman, M.D., John W. Herbst, M.D.,
 Steven S. Krogh, M.D. (3)
 Ogden Enfred E. Linder, M.D.
 Orange City Roy J. Hossebroek, M.D., Carl D. Vonder Kooi,
 M.D.
 Osceola James D. Kimball, M.D.
 Oskaloosa R. Michael Collison, M.D.

Ottumwa Stanley I. Levine, M.D.
 Red Oak William G. Artherholt, D.O. (3), Jock D. Fickel,
 M.D.
 Reinbeck Wouter H. Verduyn, M.D.
 Rockford Russell G. Borrett, M.D.
 Soc City Rodney H. Miller, M.D.
 Sheldon Ronald L. Zoutendom, M.D.
 Shenandoah Kenneth J. Gee, M.D.
 Sioux Center Richard A. Jongewoord, M.D.
 Sioux City Clark Hyden, M.D., William L. Jackson, M.D., Roy
 Sturdevont, M.D., E. L. Von Bromer, M.D.
 Spencer John E. Kelly, M.D. (5)
 Spirit Lake Donald F. Rodowig, M.D. (2)
 State Center Lorry R. Beoty, M.D.
 Storm Lake Timothy K. Daniels, M.D., Gory C. Olson, M.D. (2)
 Story City Charles E. Semler, M.D.
 Vinton Shermon L. Anthony, M.D. (3)
 Wapello Leslie E. Weber, Jr., M.D.
 Waterloo Hridendro N. Bosu, M.D. (2)
 Waukon Richard D. Perry, M.D. (2), Bill R. Withers, M.D. (3)
 Waverly James W. Rothe, M.D.
 Webster City Subhosh C. Sohal, M.D.
 West Union Lorry H. Boeke, M.D., Susan Urbotsch, M.D.
 Winfield Bill R. Nordyke, M.D.

1979-80 PRECEPTORS FOR FOURTH YEAR ELECTIVE PRECEPTORSHIP

Served Students from Class of 1980

Cedor Rapids Mark Tyler, M.D.

Estherville John Powers, M.D.
 Grinnell James B. Poulson, M.D., Bernhard Wiltfong, M.D.
 Le Mors James E. Powell, M.D.
 Red Oak William G. Artherholt, D.O., Jock D. Fickel, M.D.
 Rockford Russell Borrett, M.D.
 Shenandoah Kenneth Gee, M.D.

1979-80 PHYSICIAN'S ASSISTANT PROGRAM PRECEPTORS

Centerville Anthony Owco, M.D.
 Clarindo Kirpol Singh, M.D.
 Davenport Gordon Chervitz, M.D., Eugene Johnson, M.D.,
 John Sinning, Jr., M.D., Forrest Smith, M.D.
 Des Moines Michael Abrams, M.D., Albert Bostrom, M.D.,
 L. R. Drogstedt, M.D., John Hess, Jr., M.D., David
 Koung, M.D., Aldo Knight, M.D., Un Bong Lee,
 M.D., Thomas Lucos, M.D., Donald Lulu, M.D.,
 Loron Porker, M.D., Rizwon Shoh, M.D., Sutin
 Srisumrid, M.D., Dennis Wolter, M.D.
 Dubuque Allen Horves, M.D., Poul Loube, M.D., Robert Mel-
 goord, M.D., Peter R. Whitis, M.D.

Iowa City Michael Bonfiglio, M.D., Albert Crom, M.D., David
 Culp, M.D., Gerold DiBono, M.D., Nelson J. Gurll,
 M.D., Douglas Loube, M.D., Thomas Vorgish,
 M.D., Creighton B. Wright, M.D.
 Loke City James Comstock, M.D.
 Moson City Morie Alcorn, M.D., John K. McGregor, M.D.,
 Richard Munns, M.D.
 Marshalltown Axel Lund, M.D.
 Mt. Pleasont Curtis Fredrickson, M.D., Albert Koplon, M.D.,
 Bruce Smith, M.D., Condiah Thiogorojoh, M.D.
 Muscotine William Cotonono, M.D., Forrest Deon, M.D.,
 Charles Honnold, M.D., Steve Krogh, M.D., David
 Kundel, M.D., Deon McGinty, M.D.
 Vinton Shermon L. Anthony, M.D.
 Waterloo Thomas Coburn, M.D., Dole Phelps, M.D., Robert
 Singer, M.D., Luke Ton, M.D.

May 13 Symposium on Infectious Diseases

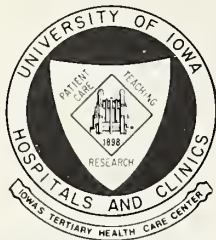
On Wednesday, May 13, the Davenport Mercy/St. Luke's Family Practice Program will sponsor a day-long Symposium on Infectious Diseases. The conference will occur at Mercy Hospital in Davenport starting at 8 a.m. The program is approved for 7 hours of CME credit. For further information write the Davenport Family Practice Program, 516 West 35th Street, Davenport, Iowa 52806 or call 319/386-3708.

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DRUG THERAPY REVIEW



UNIVERSITY OF IOWA HOSPITALS AND CLINICS

REYNOLD SPECTOR, M.D., Editor

TOTAL PARENTERAL NUTRITION: PROCEDURES AND SOLUTIONS

THE DECISION to begin treatment with parenteral nutrition should be based on sound and clear indications. Many factors influence the choice of the method to be selected and the time of introduction. The age of the patient, degree of catabolism, anticipated duration of gastrointestinal dysfunction, and pre-existing deficits are important considerations. The use of parenteral nutrition may be intended for therapeutic purposes or nutritional support during periods when the gastrointestinal tract cannot or should not be used (See the January, 1981 JOURNAL OF THE IOWA MEDICAL SOCIETY for a discussion of the indications for total parenteral nutrition.)

After a decision to use parenteral nutrition is made, the method chosen will depend on the previously cited considerations. In the vast majority of patients, "standard" total parenteral

nutrition by the central venous route, will prove to be the most appropriate method. Details of the procedures involved in applying the "standard" method include instructions and precautions in regard to catheter placement, prescribing solution orders, and monitoring and care of the patient to avoid potential complications.

Strict observation of the details of catheter placement and sterile technique are essential to reduce the incidence of complications. Catheter placement, like any operative procedure, should be scheduled during normal working hours. Proper time should be allowed and reserved for the insertion of the catheter. Even though the insertion may be undertaken on a nursing unit at patient's bedside, operating room techniques should be observed. Catheter insertion has produced significant morbidity and occasional mortality. The total parenteral nutrition (TPN) nursing team should prepare the patient, make available the needed materials and instruments, and assist in catheter insertion. This procedure should never be undertaken on an emergency basis, nor should it be regarded as something to be done during spare time.

Proper positioning of the patient and probing the anticipated path of the catheter with a thin needle are only two examples of details that may make the insertion easier and safer. Unfortunately, the perfect catheter has not yet been developed. Although it is anticipated that silicone catheters will reduce thrombus formation, the available brands present difficulties in insertion, fixation, and subsequent care. The TPN nursing team is responsible for catheter care from the time of insertion to the time of removal. Frequent dressing changes (three times weekly) using an aseptic technique contribute to the low incidence of catheter sepsis currently observed. Less frequent dressing changes or changes by unspecialized personnel may adversely affect the incidence of catheter sepsis. A new plastic dressing (Op-Site®) may require less frequent changes.

Orders for the formulation of the solution involve knowledge of the solutions available and the theoretical and practical principles behind their use. The *standard* solution is an admixture of 50% dextrose solution (the caloric source) and 8.5% crystalline amino acids solution (the nitrogen source). When equal

This information for Iowa physicians is furnished and sponsored by the University of Iowa Hospitals and Clinics.

amounts of these basic solutions are mixed, they yield a final concentration of 25% dextrose and 4.25% amino acids. Crystalline amino acids are probably superior to protein hydrolysates (fibrin or casein) as a source of protein. At The University of Iowa Hospitals, the crystalline amino acid solution, Travasol®, with or without electrolytes, is currently used. FreAmine II®, FreAmine III®, Aminosyn®, and Veinamine® are other crystalline amino acids that are commercially available. Because of their high cost, the use of the L-essential amino acid solutions (Nephramine®) is feasible only for the treatment of renal failure. When parenteral nutrition is needed in patients with liver failure, a solution rich in branched chain amino acids could be used. Lipid emulsions, in the *standard technique*, are used only for prevention of fatty acid deficiency, not for their caloric value. Fat emulsions are available in 10% concentrations (Intralipid). Two to three bottles weekly should provide essential fatty acids in excess of the minimum daily requirements.

Adequate electrolytes to meet the normal daily requirements are provided in the "Travasol® with electrolytes" solution. Considerable acetate salts are present to compensate for the acidic load contained in the amino acids. Additional electrolytes should be prescribed to replace excessive losses or to correct pre-existing deficits. Two elements deserve special mention because their serum values do not appear on the SMA 6/60 (phosphate), or the routine lab work (magnesium). Adequate supplies of those two elements are present in Travasol® with electrolytes, but, in some cases, additional phosphate or magnesium should be added to the mixture if indicated. As Travasol® is devoid of calcium salts, one to two ampules of calcium gluconate should be added to the TPN solutions daily. Since calcium and phosphate may be incompatible in solution, depending on their concentrations, it is advisable to contact the pharmacy before prescribing additional phosphate supplementation in a bottle containing calcium.

Vitamins are essential for metabolic pathways and should be added to the solution. Available vitamin solutions include "MVI®" which contains considerable concentrations of vitamins D and A in addition to B and C. To avoid vitamin D excess, MVI® should be used every other day (or approximately 3 times weekly.) Solu-B with C® is used on the alter-

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Description: Each Anusol-HC Suppository contains hydrocortisone acetate, 10.0 mg; bismuth subgallate, 2.25%; bismuth resorcin compound, 1.75%; benzyl benzoate, 1.2%; Peruvian balsam, 1.8%; zinc oxide, 11.0%; also contains the following inactive ingredients: dibasic calcium phosphate, and certified coloring in a hydrogenated vegetable oil base.

Each gram of Anusol-HC Cream contains hydrocortisone acetate, 5.0 mg; bismuth subgallate, 22.5 mg; bismuth resorcin compound, 17.5 mg; benzyl benzoate, 12.0 mg; Peruvian balsam, 18.0 mg; zinc oxide, 110.0 mg; also contains the following inactive ingredients: propylene glycol, propylparaben, methylparaben, polysorbate 60 and sorbitan monostearate in a water-miscible base of mineral oil, glyceryl stearate and water.

Anusol-HC Suppositories and Anusol-HC Cream help to relieve pain, itching and discomfort arising from irritated anorectal tissues. These preparations have a soothing, lubricant action on mucous membranes, and the antiinflammatory action of hydrocortisone acetate in Anusol-HC helps to reduce hyperemia and swelling.

The hydrocortisone acetate in Anusol-HC is primarily effective because of its antiinflammatory, antipruritic and vasoconstrictive actions.

Indications and Usage: Anusol-HC Suppositories and Anusol-HC Cream are adjunctive therapy for the symptomatic relief of pain, itching and discomfort in: external and internal hemorrhoids, proctitis, papillitis, cryptitis, anal fissures, incomplete fistulas, pruritus ani and relief of local pain and discomfort following anorectal surgery.

Anusol-HC is especially indicated when inflammation is present. After acute symptoms subside, most patients can be maintained on regular Anusol® Suppositories or Ointment.

Contraindications: Anusol-HC Suppositories and Anusol-HC Cream are contraindicated in those patients with a history of hypersensitivity to any of the components of the preparations.

Warnings: The safe use of topical steroids during pregnancy has not been fully established. Therefore, during pregnancy, they should not be used unnecessarily on extensive areas, in large amounts or for prolonged periods of time.

Precautions: General: Symptomatic relief should not delay definitive diagnoses or treatment.

Prolonged or excessive use of corticosteroids might produce systemic effects.

If irritation develops, Anusol-HC Suppositories and Anusol-HC Cream should be discontinued and appropriate therapy instituted.

In the presence of an infection the use of an appropriate antifungal or antibacterial agent should be instituted. If a favorable response does not occur promptly, the corticosteroid should be discontinued until the infection has been adequately controlled.

Anusol-HC is not for ophthalmic use.

Pregnancy

See "WARNINGS"

Pediatric Use

Care should be taken when using the corticosteroid hydrocortisone acetate in children and infants.

Dosage and Administration: Anusol-HC Suppositories—

Adults: Remove foil wrapper and insert suppository into the anus. Insert one suppository in the morning and one at bedtime for 3 to 6 days or until inflammation subsides. Then maintain comfort with regular Anusol Suppositories.

Anusol-HC Cream—Adults: After gentle bathing and drying of the anal area, remove tube cap and apply to the exterior surface and gently rub in. For internal use, attach the plastic applicator and insert into the anus by applying gentle continuous pressure. Then squeeze the tube to deliver medication. Cream should be applied 3 or 4 times a day for 3 to 6 days until inflammation subsides. Then maintain comfort with regular Anusol Ointment.

NOTE: If staining from either of the above products occurs, the stain may be removed from fabric by hand or machine washing with household detergent.

How Supplied: Anusol-HC Suppositories—boxes of 12

(N 0071-1089-07) and boxes of 24 (N 0071-1089-13) in silver foil strips with Anusol-HC printed in black.

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DRUG THERAPY REVIEW

(Continued from page 163)

nate days. Because they are not included in the available multivitamin preparations, the following should be given once weekly: vitamin B₁₂, 30 mcg; vitamin K, 10 mg; and folic acid, 10 mg. Trace element deficiency may become manifest clinically late in the course of parenteral nutrition or early if significant deficits pre-exist. Addition of trace elements is recommended for patients after the second week or if a deficiency is apparent. A combined trace element solution is available in our pharmacy and contains adequate concentrations of zinc, copper, manganese, and chromium. Ten milliliters per day will provide the recommended dose for the average adult patient. The above elements are also available separately if needed for individual supplementation or correction of isolated deficiency states. Iodide in oral solutions and intramuscularly injected iron can be administered to the patient but are rarely needed. Adding iron salts to the intravenous infusion cannot be recommended. Despite some reports of its safety when given intravenously, the evidence is not yet conclusive.

Although the routine addition of insulin to TPN solutions should not be practiced, it may be needed to control persistent hyperglycemia. Only in significant hyperglycemia should insulin be added to the mixture. The prescribed dose should be carefully calculated based on blood sugars and urinary fractionals measured over two to three days. When adding insulin to TPN bottles (as opposed to subcutaneous injection), doses may need to be adjusted because some of the insulin adheres to the bottle and tubing.

A special order form (the "Adult Venous Nutrition Orders," Form A-1a-AVN) for parenteral nutrition is available for use at The University of Iowa Hospitals. One section in the form describes the basic solutions available. If the *standard method* is to be used (50% dextrose in water and 8.5% Travasol® with or without electrolytes), the amounts to be used should be indicated in the appropriate columns. The concentration of one substance (e.g., glucose or amino acids) can be altered in the final mixture by changing the relative

volume of the basic solution. For example, 500 ml of 50% D/W and 500 ml of 8.5% Travasol® give a final glucose concentration of 25% and Travasol® 4.25%. Three hundred ml of 50% D/W, 500 ml of 8.5% Travasol® and 200 ml of sterile water for injection yield a final glucose concentration of 15%. Lower concentrations of glucose may be achieved by using a 20% D/W basic solution (available now in our pharmacy). Such manipulation may become indicated for correction of fatty liver, secondary to excessive caloric intake, or to supply extra needed water without increasing the caloric intake. However, manipulation of formulas in this manner increases costs and personnel time expended, and should be undertaken only when clearly indicated.

If parenteral nutrition with peripheral amino acids (protein sparing) is the method to be chosen, the appropriate solution (3.5% Travasol M with electrolyte 45®) should be marked and the rate stated. If the lipid system is to be used, the dextrose-amino acid mixture should be marked (equal volumes of 10% dextrose injection and 8.5% Travasol® with or without electrolytes) as well as the fat emulsion (10%, Intralipid®), and the rates of infusion stated.

The second section of the form is for electrolyte additives if needed. Calcium is not supplied in the basic solutions and should be prescribed daily. The third section is for vitamins, and the fourth section is for miscellaneous additives. The number of each bottle, rate of infusion, and scheduled time and date should be stated.

For a safe and satisfactory outcome, patient monitoring and catheter care are of utmost importance during the course of parenteral nutrition. After uncomplicated catheter insertion and correct position are verified, the principal hazards become catheter sepsis and major vein thrombosis. Sepsis is almost totally obviated by frequent aseptic dressing changes undertaken by specialized personnel. When catheter sepsis is suspected, the TPN solution should be discontinued and cultured. If fever continues for 24 hours and other sources are not identified, the catheter should be removed and the tip cultured. Blood cultures should also be obtained on these occasions. Antibiotics are not necessary for treatment of catheter sepsis. New catheters may be inserted when fever abates or if another cause for the fever is identi-

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DRUG THERAPY REVIEW

(Continued from page 165)

fied. Seeding of catheters from bacteremia is uncommon and should not contraindicate resumption of venous nutrition.

The incidence of major vein thrombosis may be related to the type of catheter but is also dependent on the development of phlebitis in veins smaller than the superior vena cava (e.g., subclavian or internal jugular). Silicone catheters are preferable, and the tip of the catheter should always be in the superior vena cava. Catheters with the tips in the subclavian, internal jugular, or brachiocephalic veins should not be accepted for hyperalimentation. The addition of heparin to the solution, though claimed to decrease the incidence of thrombosis, is not recommended because of lack of documentation.

In general, serum electrolytes (SMA 6/60) should be monitored three times weekly, liver function tests (SMA 12/60) should be checked

twice weekly, and serum magnesium, osmolality, CBC, PT, and PTT should be checked once weekly. The frequency of such monitoring should, of course, be adjusted to the patient's condition.

Complications related to glucose infusion are essentially the consequences of hyperglycemia; namely, glucosuria, polyuria, dehydration, hyperosmolality, and finally hyperosmolar nonketotic coma. Such complication may prove fatal. Other complications may be related to the other ingredients, minerals, vitamins, or other additives. Crystalline amino acid solutions are associated with fewer complications as compared to protein hydrolysates. Metabolic acidosis is a potential complication, but is rare with the use of Travasol® with electrolytes because of the amount of acetate present. Electrolyte imbalances may be severe. Chloride and bicarbonate levels reflect the acid base balance and should be appropriately observed and corrected. When additional bicarbonate is judged needed, acetate salts of potassium or sodium should be used, which will be metabolized to bicarbonate.

Liver dysfunction, as a complication of parenteral nutrition, is observed infrequently and usually is transient. It reflects the development of fatty liver due to an excessive glucose load and persistent hyperinsulinemia. Liver dysfunction has also been attributed to other mechanisms. The potential presence of toxic products in the amino acid solutions and protein hydrolysates, the deficiency of lipotropic substances (choline and methionine), and essential fatty acid deficiency have all been suggested. Corrective therapy depends on which mechanism is implicated. The intermittent addition of exogenous fat emulsion and the reduction of hyperinsulinemia by reducing the glucose concentration or using cyclic hyperalimentation may be effective. Often, however, this is a self-limiting process. Liver dysfunction and glucose intolerance may herald or accompany unsuspected or established sepsis.

Detailed assessment of the nutritional status prior to, during, or after parenteral nutrition is not necessary in the vast majority of adult patients. The decision to utilize parenteral nutrition (when the gastrointestinal tract is not usable) in the management of a patient is based essentially on clinical indications, notwith-

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standing the pre-existing deficit. A patient with pancreatitis, short bowel syndrome, radiation enteritis, or gastrointestinal fistula will receive parenteral nutrition regardless of his (or her) nutritional status. Nutritional deficits rarely modify the solution to be used and, by themselves, are rarely if ever an indication for parenteral nutrition, unless the use of the gastrointestinal tract is not possible or desirable. A rough estimate of basal energy expenditure is acceptable and helpful for estimating the total daily caloric needs. Extra calories (up to 50% of the estimated requirements) are generally advisable when the nutrients are introduced parenterally. It is far superior to introduce parenteral nutrition before major deficits develop than to correct established deficits. When the indications for parenteral nutrition no longer exist or the gastrointestinal tract function is regained, parenteral nutrition should be discontinued. Improvement of nutritional status is not by itself the goal of parenteral nutrition. In fact, a gain in somatic

proteins may not be possible with relatively short periods of TPN without physical exercise. The clinical course, body weights, and serum albumin measurements are simple but sufficient guidelines for assessing the nutritional status. — ADEL AL-JURF, M.D., *Assistant Professor of Surgery*, and JOHN G. ROSE, R.Ph., *University of Iowa Hospitals*

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REGIONAL GENETIC COUNSELING IN IOWA/ A STATUS REPORT

GENETIC COUNSELING has been available in the State of Iowa for 20 years. Until recently, however, this was available only in Iowa City at the University Hospitals. In 1976, the General Assembly established a Birth Defects Institute within the Iowa State Department of Health and appropriated funds to develop a statewide program of genetic health services. Subsequently, with assistance from the University Hospitals Division of Medical Genetics, a statewide Regional Genetic Consultation Service (RGCS) has been implemented.

The aims established for the RGCS were to:

1. Educate health professionals and the general public about genetics and genetic counseling.
2. Increase the accessibility to genetic counseling.
3. Provide diagnostic and informative genetic counseling in conjunction with the local medical community.
4. Provide supportive and follow-up genetic counseling, which is believed to significantly improve the quality and effectiveness of the genetic counseling process.

During the past 4 years the RGCS staff has

This information on public health matters is furnished and sponsored by the Iowa State Department of Health.

presented approximately 600 educational programs to Iowa health professionals and the general public. This has tremendously increased awareness to the value of genetic counseling.

Fifteen regional clinic sites have been established to form a statewide network of genetic counseling clinics. This increased accessibility to genetic counseling throughout the state has been reflected in increased utilization of clinic services. In 1975-76 there were approximately 300 clinic visits at the University Hospitals for genetic counseling. By 1979-80 the combined RGCS-University Hospitals services had grown by 600% to nearly 2,000 visits per year.

We have recently evaluated the services provided by the RGCS through a questionnaire mailed to 1,130 families. Close to 600 families responded.

Almost half of the families seen in the regional genetic counseling clinics are referred by the local medical community (Table 1). Regardless of referral source, reports are sent to the local physician, unless the family requests otherwise.

TABLE 1
REFERRAL SOURCE

LOCAL MEDICAL COMMUNITY (M.D.'s, R.N.'s, hospital and clinic staff)	44%
UNIVERSITY OF IOWA MEDICAL COMMUNITY (SSCC, Hosp. School, specialty clinics)	20%
SELF	25%
Medio (12%)	
Relatives (8%)	
Friend (3%)	
Self (2%)	
EDUCATIONAL SYSTEM (AEA, Schools)	5%
OTHER ORGANIZATIONS (Parent, MDA, MOD)	2%
SOCIAL AGENCIES	1%
REFERRAL SOURCE UNKNOWN	3%

Information provided at the genetic counseling clinics is often complex and difficult to comprehend. Recall of this information is often not satisfactory. Nevertheless, we have been pleased to find that many families are able to recall essential information (Table 2). Diminishing recall over time was apparent in this study. This reduction in recall points to the importance of continuing follow-up contacts

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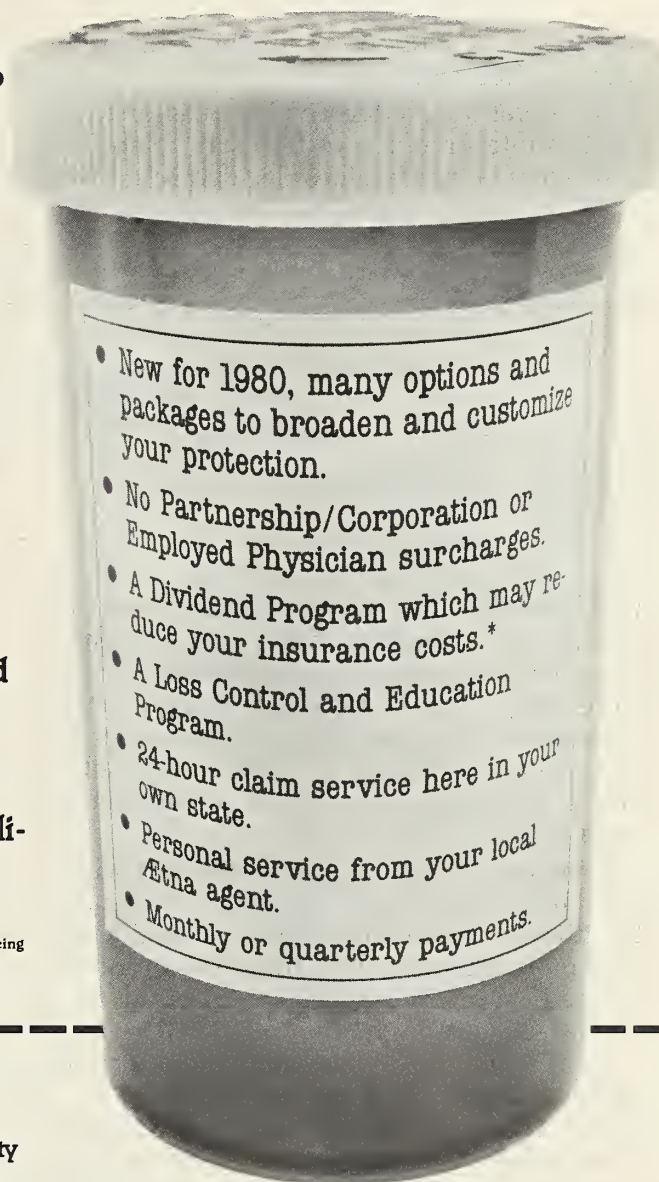
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TABLE 2
ABILITY TO ACCURATELY RECALL DIAGNOSIS, INHERITANCE,
AND RECURRENCE RISK

	Diagnosis	Inheritance*	Risk*
Yes	539 = 94%	438 = 78%	353 = 71%
No	34 = 6%	125 = 22%	144 = 29%
	573	563	497

* Only if applicable.

not only by genetic counselors but also by the local medical community.

There was a high degree of correlation in the family's interpretation of risk with that of the counselors. What families decided to do with

this group the average recurrence risk is between 25 and 50%. Thus a more likely minimum estimate of avoided affected children would be 14-29 children.

The present cost for one day in a state supported institution for the mentally retarded in Iowa is over \$100. If the child lives 10 to 20 years the cost reaches \$350,000-\$700,000. The prevention of one such child more than covers the amount of money spent on genetic counseling services throughout Iowa. These figures of course do not take into consideration the cost of human pain and suffering which is very difficult to evaluate in financial terms.

In addition to providing information about a specific genetic disorder, its prognosis, and management, an attempt is made to provide

TABLE 3
COMPARISON OF COUNSELOR'S INTERPRETATION WITH CHANGE IN PLANS FOR HAVING CHILDREN

		Changes in Family Plans					N
		No Change	No More	Fewer	More	Unknown	
Counselor Risk	Low (<10%)	168 (67%)	14 (6%)	28 (11%)	30 (12%)	10 (4%)	250
Interpretation	High (>10%)	51 (45%)	22 (19%)	36 (31%)	1 (1%)	6 (5%)	116

the information they received varied from case to case. Many families indicated their family plans had changed after receiving genetic counseling (Table 3). Although changing family plans is not a goal of genetic counseling, information provided in genetic counseling clinics sometimes does have an impact on these plans.

In the low risk group (those families with a risk <10%), 30 of the 250 families (12%) stated that after genetic counseling they decided to have more children than they had originally planned, a result noticeably different from families facing a high risk.

There were 116 families which fell into the high risk group (those with a risk \geq 10%). Of those 116 families, 58 (50%) stated, after genetic counseling, they decided to have no more or fewer children than they originally planned to have. Since the risk these families faced was 10% or greater, a crude minimum estimate of the number of affected children who would have been born to these families, had they each had one child is 5.8 children. In fact, within

supportive counseling. Genetic counselors attempt to assist families with the grief process, support them in making their own decisions about further reproduction and provide information about other support services. Of the 508 families who responded, 93% stated that after genetic counseling, they felt better able to cope with the problem present in their family.

Of those responding to the questionnaire, 97% said they were satisfied with the service they received, while 99% stated they would recommend the service to others.

This survey indicates genetic counseling is gaining substantial acceptance by medical professionals and the Iowa public. Furthermore, this preliminary analysis suggests that such services are cost effective and represent a valuable addition to our health care system. If the potential advantages of this program are to be realized the continued advice and support of Iowa's health community is vital.

(Please turn to page 171)

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Final classification of the less-than-effective indications requires further investigation.

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tion-prone individuals or those who might increase dosage, withdrawal symptoms (including convulsions) reported following discontinuation of the drug.

Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy. Advise patients to discuss therapy if they intend to or do become pregnant.

As with all anticholinergics, inhibition of lactation may occur.

Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude ataxia, oversedation, confusion (no more than 2 capsules/day initially, increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacology of agents, particularly potentiating drugs such as MAO inhibitors, phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions reported in psychiatric patients. Employ usual precautions in treating anxiety states with evidence of impending depression: suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation reported very rarely in patients receiving the drug

and oral anticoagulants; causal relationship not established.

Adverse Reactions: No side effects or manifestations not seen with either compound alone reported with Librax. When chlordiazepoxide HCl is used alone, drowsiness, ataxia, confusion may occur, especially in elderly and debilitated; avoidable in most cases by proper dosage adjustment, but also occasionally observed at lower dosage ranges. Syncope reported in a few instances. Also encountered: isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent, generally controlled with dosage reduction; changes in EEG patterns may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice, hepatic dysfunction reported occasionally with chlordiazepoxide HCl, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax typical of anticholinergic agents, i.e., dryness of mouth, blurring of vision, urinary hesitancy, constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.



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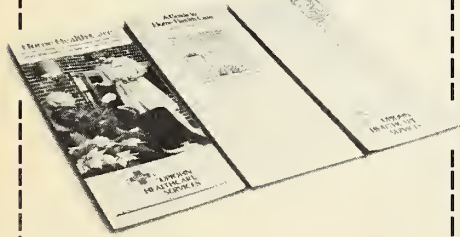
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February 1981 Morbidity Report

Disease	Feb. 1981 Total	1981 to Date	1980 to Date	Most Feb. Cases Reported From These Counties
Amebiasis	0	0	0	
Brucellosis	0	0	0	
Chickenpox	1333	2691	2637	Scattered
Cytomegalovirus	0	2	1	
Eaton's Agent infection	5	8	2	Dubuque
Encepholitis, virol	0	1	4	
Erythema infectiosum	64	227	41	Poweshiek, Calhoun, Black Hawk
Gastroenteritis (GIV)	3603	6603	6841	Linn, Johnson, Polk
Giordiosis	3	9	5	Hamilton, Story, Tama
Hepatitis, A	27	61	19	Scott, Des Moines
Hepatitis, B	6	13	14	Scattered
type unspecified	6	11	17	Scattered
Herpes Simplex	24	32	19	Johnson
Herpes Zoster	1	2	0	Linn
Histoplasmosis	0	3	7	
Infectious mononucleosis	42	74	87	Linn, Polk
Influenza, lob confirmed	93	125	14	Johnson, Linn, Polk, Wopello
Influenza-like illness (URI)	20547	32722	22382	Johnson, Polo Alto, Linn
Meningitis				
oseptic	10	16	6	Scattered
bacterial	5	22	23	Scattered
meningococcal	3	7	1	Linn
Mumps	13	20	12	Black Hawk
Pertussis	1	1	0	Clay
Robies in animals	65	120	47	Bentley, Chickasaw, Humboldt
Rheumatic fever	2	3	0	Polk, Warren
Rubello				
(German measles)	0	0	1	
Rubeolo (measles)	0	0	0	
Salmonello	20	32	16	Monroe, Tama
Shigellosis	1	10	21	Wopello
Tuberculosis				
total ill	17	26	11	Polk
bact. pos.	6	15	8	Polk
Venereal diseases:				
Gonorrheo	321	703	750	Polk, Mills, Poweshiek
Syphilis	3	4	4	Johnson, Linn, Winnebago

Laboratory Virus Diagnosis Without Specified Clinical Syndrome: Legionnaire's Disease — 1, Linn; Reye Syndrome — 1, Soc; Rheumatic Fever — 1, Polk, 1, Warren; Scarlet Fever — 1, Clinton, 1, Davis, 1, Des Moines, 1, Ido, 9, Jackson, 1, Linn, 5, Polk 1, Tama, 1, Warth; Blastomycosis — 1, Johnson; Echavirus — 5, Black Hawk; Malaria — 1, Lee, 1, Polk; Compylobacter — 2, Polk, 1, Woodbury; Toxic Shock Syndrome 1, Corroll, 1, Des Moines.

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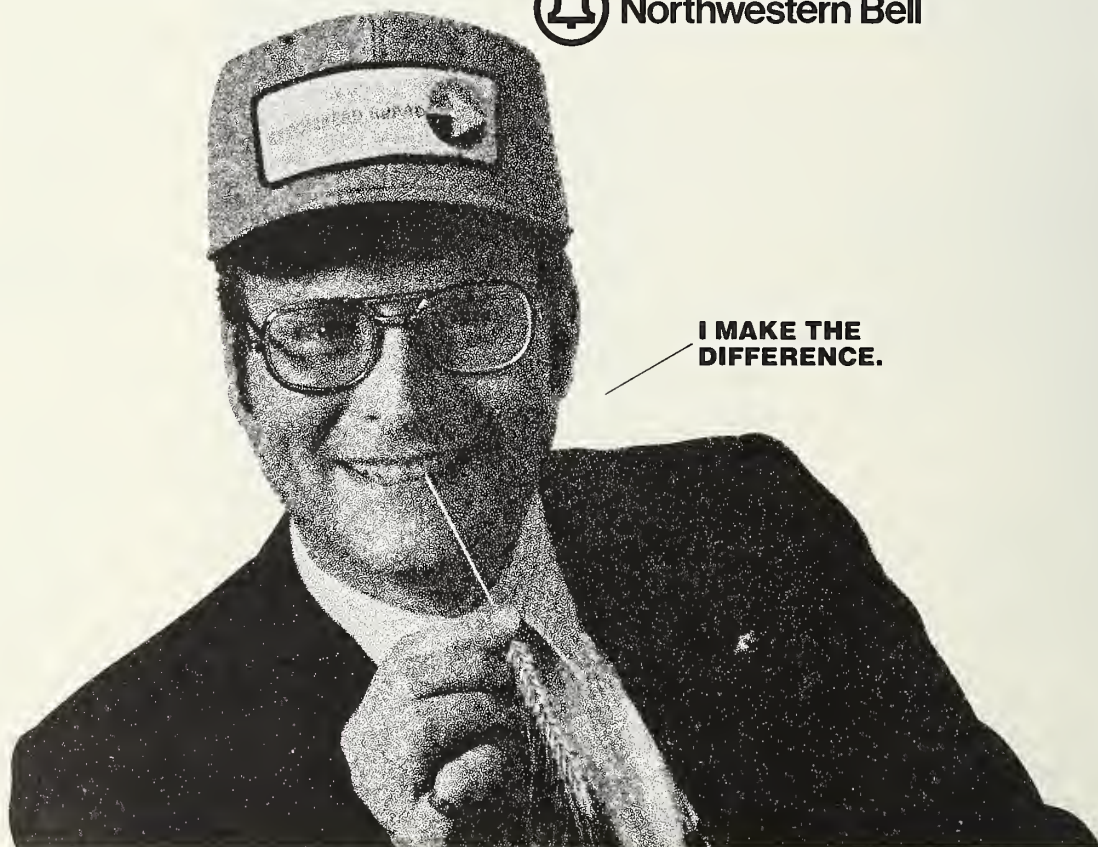
RESULT: Salesmen now have more time to go after new business. Deliveries are on time and the truck routes are more efficiently organized. And customer loyalty has improved. Maybe it's because Virg Andersen is so good at communications, or maybe it's because he comes from a country background and still has a little bit of country in him, but Virg made the difference for Arrowhead.

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ABOUT IOWA PHYSICIANS

Ames physicians **Dr. Mark Brodersen** and **Dr. Richard Lloyd** recently addressed Iowa State University veterinary medicine students. Dr. Brodersen discussed bioelectricity in fracture healing and Dr. Lloyd spoke on dermatology.

Dr. B. V. Andersen, Greene physician for over 40 years, has retired. Dr. Andersen received the M.D. degree at the University of Nebraska School of Medicine and began his medical practice in Greene in 1937. . . . **Drs. Don McCabe** and **A. Patrick Schneider**, Burlington physicians, were instructors at a recent continuing medical education course on infant resuscitation at the Fort Madison Community Hospital. . . . **Dr. Stephen P. Johnson** has opened an office in Ames for the practice of internal medicine. Dr. Johnson received the M.D. degree at Harvard Medical School. He is a diplomate of American Board of Internal Medicine and a member of American College of Physicians. . . . **Dr. William R. Blankenship**, Sioux City, was guest speaker at a recent meeting of the Siouxland Unit of the American Diabetes Association. Dr. Blankenship's topic, "Diabetes, Insulin and Diabetic Pills." . . . **Dr. Robert M. Roth** will join the W. P. Garred Medical Clinic in Onawa in July. Dr. Roth received the M.D. degree at Tufts University School of Medicine in Boston, Massachusetts. He is currently completing a family practice residency at the Hamot Medical Center in Erie, Pennsylvania.

DEATHS

Dr. Geoffrey W. Bennett, 74, former Oskaloosa physician, died February 11 in Phoenix,

Arizona. Dr. Bennett received the M.D. degree at U. of I. College of Medicine and interned in Detroit, Michigan. He began his medical practice in Oskaloosa in 1936, retiring in 1978. Dr. Bennett was a member of the International College of Surgeons; Iowa Clinical-Surgical Society; and fellow of the American Geriatric Society.

Dr. Robert W. Brindley, 59, Mason City, died February 15 at his home. Dr. Brindley received the M.D. degree and completed his psychiatric residency at the U. of I. College of Medicine. He was director of the Mental Health Center of North Iowa, psychiatric consultant for the Gerard Schools of Iowa, and in private practice at Forest Park Medical Center in Mason City.

Dr. James Dyson, 90, longtime Des Moines pediatrician, died February 18 at his home. Dr. Dyson received the M.D. degree at the University of Minnesota and completed his pediatric residency at the University of Chicago. He was a past president of the Polk County Medical Society and life member of the Iowa Medical Society.

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In The Public Interest

Praise For Preceptors



FOR MANY University of Iowa medical students, the 2-week required preceptorship in the junior year is a significant experience. It is a time to be with an Iowa doctor in his private practice setting.

Iowa medical student preceptees react usually with enthusiasm when introduced this way to the wide range of experiences which

an alcohol treatment center.

Kris Beckwith, Coralville junior, preceptee with Wayne Rouse, M.D., Boone

Involved in learning situations addressing clinical problems in an office setting with mechanisms to insure continuous comprehensive care . . . learning how to evaluate and treat patients as a part of a family in the community setting . . . learning preventive health care measures and continuing education . . . I am now considering family practice.

Dominic Frecentese, West Des Moines junior, preceptee with John Barnes, M.D., Missouri Valley

Increased awareness of the diseases seen by a



confront the practicing physician. Following are typical reactions of both medical and physician's assistant students:

Sharon Goodwin, Mt. Pleasant junior, preceptee with Glen Gabrielson, M.D., Ft. Madison

Excellent amount of time spent in patient education . . . preceptor very willing to spend time in answering my questions and teaching . . . active practice with a good variety of patients seen . . . supported my interest in family practice."

Jeffrey Lenz, Independence junior, preceptee with John Kelly, M.D., Spencer

A chance to apply problem solving methods . . . exposure to therapy, surgical and medical . . . outpatient office practice . . . lots of first-hand experience . . . I plan to return for 4 additional weeks in my senior year. I am now reconsidering a career in family practice.

Jon Thomas, Council Bluffs junior, preceptee with James Mulry, M.D., Council Bluffs

Insight into business aspects of medical practice . . . exposure to office counseling . . . exposure to alcohol treatment and detoxification . . . one of the best learning experiences of the junior year . . . preceptor is an excellent, enthusiastic teacher, a down-to-earth person who does a lot of OB and heads

primary care physician and how to treat them . . . chance to observe how a successful practice is integrated into a good family life . . . preceptor seemed to know what procedures I was comfortable performing and the amount of duties I could assume, and he geared the two weeks to my needs.

Deborah Austin, Rochester, Minn., PA student, preceptee with Gordon Cherwitz, M.D., Davenport

Excellent teacher, patient, humanistic, encouraging . . . preceptor spends time at patient education and counseling psycho-social problems.

Richard Koffend, Chicago, Ill., PA student, preceptee with Anthony S. Owca, M.D., Centerville

Absolutely topnotch preceptor, physician and person . . . an excellent opportunity to learn both medicine and the art of it in a private practice setting . . . an invaluable chance to meet wonderful people and enhance medical knowledge.

The door is always open to Iowa physicians who may want to be preceptors. Let us know at Iowa Medical Society headquarters.

April 1981

Journal of the Iowa Medical Society

What Are Iowa Physicians Thinking?

As might be expected, some 97% of Iowa's physicians believe medical care in their areas of the state is at its highest level of quality in their time there.

On a further topic of current interest, 61% of Iowa physicians either agree or strongly agree the state will have an excess of physician manpower by 1990.

These two findings are drawn from the results of a January 1981 survey of Iowa Medical Society member physicians. This data-gathering project of the IMS Board of Trustees involved the distribution of 3,126 questionnaires on January 19. 1,146 (36%) of the 61-part survey were returned.

Highlights of the Iowa physician opinion poll were reported to the IMS House of Delegates at its annual session in Des Moines May 2 and 3. Findings of the survey will help the Board of Trustees and other Society components determine priorities and strategies in the coming months.

On the next two pages are the tabulated highlights of this 1981 Iowa physician poll. The information may be of interest to readers of the IMS JOURNAL. Appreciation is expressed to those IMS members who took time to complete and return the survey.

PHYSICIAN OPINION ON IMPORTANT ASPECTS OF IOWA MEDICAL CARE

These 20 statements cover most of the important medical care subjects of the day. The level of physician agreement or disagreement is shown in percentage form as reported in the January IMS survey.

	STRONGLY AGREE	AGREE	DISAGREE	STRONGLY DISAGREE
Medical care in my area of Iowa is of as high quality as it has been during my time here →	64 %	33 %	3 %	0 %
A highly favorable attitude exists in this area among patients toward physicians →	22	68	9	1
Citizen access to <i>primary</i> care is not a problem in my area of Iowa →	36	50	12	2
Citizen access to <i>specialty</i> care is not a problem in my area of Iowa →	42	49	8	1
The cost of care is not mentioned by my patients any more than any earlier year →	19	52	26	3
Payments made directly by patients have slowed noticeably with the economic downturn →	7	48	42	3
Fee determinations made by third parties (other than government) are generally at an equitable level →	2	54	35	9
Fee determinations made by government formula (Medicare, Medicaid) are at an acceptable level →	1	16	51	32
The voluntary efforts to restrain health care costs increases have helped to curtail the increases in our area →	7	63	27	3
Hospital beds in my area of Iowa are being used as near maximum efficiency as possible →	19	54	22	5
The use of outpatient medical services has increased steadily in my area of Iowa over the past 5 years. →	31	60	9	0
The availability of emergency medical services in my area of Iowa has improved substantially over the past 5 years →	37	54	8	1
The presence of limited practitioners (physician's assistants, nurse practitioners) has been beneficial to medical care delivery in my area of Iowa →	6	27	50	17
The presence of governmentally required and regulated health planning has been beneficial to my area of Iowa →	1	14	58	27
The participation by Iowa physicians in formal health planning activities has been good →	5	68	24	3
The physician peer review activity coordinated by the Iowa Foundation for Medical Care is having a positive effect on medical care delivery →	6	57	29	8
There is a definite public interest in health maintenance organizations →	4	36	53	7
The requirement of continuing medical education for licensure in Iowa is a good development →	20	56	18	6
The professional liability climate in my area of Iowa is worsening →	6	37	54	3
Iowa will likely have an excess of physician manpower by 1990 →	15	46	35	4

PRIORITIES AS SEEN BY IOWA PHYSICIANS

Listed here are percentages showing the level of priority reporting Iowa physicians believe should be assigned by the Iowa Medical Society to the medical care issues of the day.

	MUCH HIGHER PRIORITY	ABOUT SAME PRIORITY	LESS PRIORITY	NO OPINION
Cost of medical care	39 %	58 %	2 %	1 %
Development of HMOs/IPAs	10	33	52	5
Role of limited practitioners	15	38	41	6
Funding/Medicaid	30	55	10	5
Funding/Family Practice Residency Program	13	56	27	4
Funding/Board of Medical Examiners	18	66	13	3
Physician peer review	16	65	18	1
Troubled physician assistance	33	59	6	2
Discipline of physicians	35	59	5	1
Public image of physicians	50	45	4	1
Physician manpower	14	68	16	2
Liability claims prevention/risk management	31	61	5	3
Continuing medical education	19	64	16	1
Hospital/medical staff relations	14	71	12	3
Health planning participation	24	64	10	2
General health legislation	31	61	5	3
Level of political participation	29	61	8	2

REASONS FOR BELONGING TO THE IOWA MEDICAL SOCIETY

Nine reasons for belonging to the Iowa Medical Society are given here. The level of importance of each has been reported and is represented by the percentages shown.

	VERY IMPORTANT	SOMEWHAT IMPORTANT	NOT IMPORTANT	NO OPINION
Representation before legislative/other governmental bodies	65 %	31 %	3 %	1 %
Representation with private third-party financing mechanisms	51	39	7	3
Representation with business/industry	33	49	15	3
Liaison with other health groups (Iowa Hospital Association, Iowa Nurses' Association, etc.)	34	54	9	3
Provision for continuing education (scientific session/accreditation activity)	28	46	25	1
Image-building (public relations), communications to the public	38	48	12	2
Provision of current medical and socioeconomic information (Journal, Update, Directory, etc.)	23	50	25	2
Availability of professional liability insurance	30	32	35	3
Other member benefits (health, life, disability insurance, travel opportunities, etc.)	12	39	45	4

Everything's Up to Date In Kansas City

So why not get updated! By attending the 1981 Iowa Medical Society Annual Scientific Session. It will be June 24 through June 26 (Wednesday through Friday) at the Alameda Plaza in Kansas City.

The 1981 IMS Scientific Session is open to member physicians and their families. There is no registration fee. Several programs will be of interest to spouses, particularly the June 24 segment which includes presentations on marriage counseling, children of divorce — and how the physician can help patients with these social problems.

Site of the 1981 IMS Scientific Session is the Alameda Plaza. It is located in the Country Club Plaza, a Spanish-styled marketplace with tree-lined sidewalks, sparkling fountains, tiled murals and statues. The area has fine shops, restaurants, nightly entertainment, all within a 3-block walking distance of the hotel.

The Alameda itself is a 14-story Spanish-styled hotel with excellent restaurants, luxurious guest rooms and possessing art treasures, including more than 1,000 antiques and art objects. It is just 10 minutes south of downtown Kansas City.

CME Credit — Eleven hours of continuing medical education credit will be available to participating physicians. This is approved both for Category I Credit/

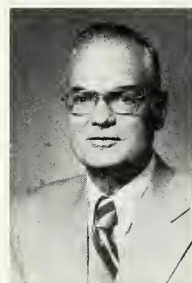
AMA Physicians Recognition Award and Prescribed Credit/American Academy of Family Physicians.

SPECIAL EVENING EVENTS — In addition to the Scientific Program, planned activities include a "get-acquainted" reception the evening of June 23; a special reception June 24 to be hosted by the Iowa Medical Political Action Committee, and a reception/banquet June 25.

AUXILIARY — The Iowa Medical Society Auxiliary will have a hospitality room and will assist anyone looking for activities. A special "quilting" instruction session will be available the morning of June 25.

RECREATION OPPORTUNITIES — Loose Park is directly behind the hotel with 4 tennis courts and a jogging tract. Other special tourist attractions include the Nelson Art Gallery, Starlight Theater, Worlds of Fun and the Truman Library.

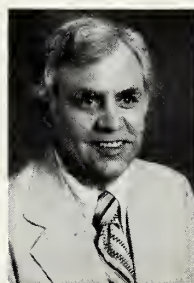
ACKNOWLEDGMENTS — Special thanks is due the following companies which have provided educational grants to the 1981 Scientific Session: Bristol Laboratories, Smith, Kline and French Laboratories, Geigy Pharmaceuticals, A. H. Robins Company, Parke-Davis, Eli Lilly and Company, CIBA Pharmaceutical Company, Blue Cross-Blue Shield of Iowa, Ayerst Laboratories and E. R. Squibb & Sons, Inc.



Dr. McCormack



Dr. Barnett



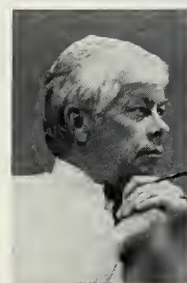
Dr. Beachy



Dr. Canady



Dr. Caplan



Dr. Hegstrom

1981 IMS PROGRAM COMMITTEE — The IMS Program Committee is chaired by William C. McCormack, M.D., Ames. Other physician members are William H. Barnett, M.D., Ames; Lester Beachy, M.D., Des Moines; George F. Canady, M.D., Jefferson; Richard M. Caplan, M.D., Iowa City, and George Hegstrom, M.D., Ames. These physicians welcome the opportunity to invite you to attend an interesting and informative program in Kansas City. It is believed those who participate will receive significant benefit — in terms of information, inspiration and relaxation.

1981 IMS Scientific Session

WEDNESDAY, JUNE 24

- 8:00 a.m. COFFEE
- 8:20 a.m. WELCOMING REMARKS/ANNOUNCEMENTS
William R. Bliss, M.D., Ames,
President, Iowa Medical Society
William C. McCormock, M.D., Ames,
Chairman, Program Committee
- 8:30 a.m. MARRIAGE COUNSELING
Beverley T. Meod, M.D., Omaha, Nebraska
Associate Dean and Professor of Psychiatry
Creighton University School of Medicine
- 9:20 a.m. THE MARRIAGE CONTRACT
Samuel M. Fahr, LL.B., Iowa City
Professor of Law
University of Iowa College of Law
- 10:30 a.m. CHILDREN OF DIVORCE
Donner Dewdney, M.D., Des Moines
Private Practice — Psychiatry
- 11:20 a.m. PANEL DISCUSSION
Dr. Meod, Professor Fohr, Dr. Dewdney
- 12:10 p.m. LUNCH & WRAP-UP
Dr. Meod
- 1:30 p.m. ADJOURNMENT

THURSDAY, JUNE 25

- 7:30 a.m. COFFEE
- 7:50 a.m. GENERAL ANNOUNCEMENTS
- 8:00 a.m. RECENT ADVANCES IN NUCLEAR MEDICINE
David F. Preston, M.D., Kansas City, Kansas
Associate Professor of Diagnostic Radiology/
Division of Nuclear Medicine
Kansas University Medical Center
- 9:00 a.m. CLINICAL APPLICATION OF ULTRASOUND
IN MEDICINE
Victoria Yiu Chiu, M.D., Iowa City
Assistant Professor of Radiology
University of Iowa College of Medicine

- 10:20 a.m. COMPUTED TOMOGRAPHY
Suresh K. Agrowal, M.D., Iowa City
Fellow Associate/Department of Radiology
University of Iowa College of Medicine
- 11:20 a.m. PANEL DISCUSSION
Dr. Preston, Dr. Chiu, Dr. Agrowal
- Noon ADJOURNMENT

FRIDAY, JUNE 26

- 7:30 a.m. COFFEE
- 7:50 a.m. GENERAL ANNOUNCEMENTS
- 8:00 a.m. ANTIBIOTICS: OLD AND NEW
Martin G. Myers, M.D., Iowa City
Associate Professor of Pediatrics
University of Iowa College of Medicine
- 8:50 a.m. DRUG THERAPY FOR CARDIAC ARRHYTHMIA
Michael J. Mirro, M.D., Iowa City
Assistant Professor of Internal Medicine
University of Iowa College of Medicine
- 10:00 a.m. DRUG THERAPY FOR ANGINA PECTORIS
David Harrison, M.D., Iowa City
Fellow Associate/Department of Internal Medicine
University of Iowa College of Medicine
- 10:50 a.m. WHICH ANTIBIOTIC FOR WHICH DISEASE
Dr. Myers
- 11:40 a.m. PANEL DISCUSSION
Dr. Myers, Dr. Mirro, Dr. Harrison
- Noon ADJOURNMENT

The program is co-sponsored by the University of Iowa College of Medicine. As an organization accredited for continuing medical education, the U. of I. College of Medicine certifies that this CME offering meets the criteria for 11 credit hours in Category I of the AMA Physicians Recognition Award, provided it is used and completed as designed. It is also approved by the American Academy of Family Physicians for 11 hours of prescribed credit.

1981 SCIENTIFIC SESSION REGISTRATION FORM

Please make the following reservations for me at the Alameda Plaza for the 1981 Scientific Session —

TYPE OF ACCOMMODATIONS	DATE OF ARRIVAL	DATE OF DEPARTURE
Single _____	June 23 _____	_____
Two Persons _____	June 24 _____	_____
(Double Bed) _____	June 25 _____	_____
(Twin Beds) _____	June 26 _____	_____
Three Persons _____	June 27 _____	_____
Four Persons _____		

Limit of 4 persons to a room, with some special exceptions, on request. Please indicate ages of children who accompany you.

NAME (Please Print) _____


ADDRESS _____

Return registration form to IMS Headquarters, 1001 Grand Avenue, West Des Moines, Iowa 50265. If you have any questions, call 1/800/422-3070.



**Acute pain
is no laughing matter.**

The first prescription for the first days of acute pain Empirin® \bar{c} Codeine #3


Each tablet contains: aspirin, 325 mg; plus codeine phosphate, 30 mg. (Warning — may be habit-forming). 

For the millions of patients who need the potency of aspirin and codeine for their acute pain.

The pain of fractures, strains, sprains, burns and wounds is at its peak during the first three to four days following trauma. The potent action of Empirin \bar{c} Codeine begins to work within 15 minutes of oral administration, an important advantage during this acute pain period. Empirin \bar{c} Codeine has unique bi-level action to attack pain at two critical points: peripherally at the site of injury and centrally at the site of pain awareness.

For the most effective dosage in treating acute pain, begin with... two tablets of Empirin \bar{c} Codeine #2 or #3, every four hours. Titrate downward as pain subsides.

EMPIRIN® with Codeine

DESCRIPTION: Each tablet contains aspirin (acetylsalicylic acid) 325 mg plus codeine phosphate in one of the following strengths: No. 2 — 15 mg, No. 3 — 30 mg, and No. 4 — 60 mg. (Warning — may be habit-forming). 

CONTRAINDICATIONS: Hypersensitivity to aspirin or codeine.

WARNINGS:

Drug dependence: Empirin with Codeine can produce drug dependence of the morphine type and, therefore, has the potential for being abused. Psychic dependence, physical dependence, and tolerance may develop upon repeated administration of this drug and it should be prescribed and administered with the same degree of caution appropriate to the use of other oral, narcotic-containing medications. Like other narcotic-containing medications, the drug is subject to the Federal Controlled Substances Act.

Use in ambulatory patients: Empirin with Codeine may impair the mental and/or physical abilities required for the performance of potentially hazardous tasks such as driving a car or operating machinery. The patient using this drug should be cautioned accordingly.

Interaction with other central nervous system (CNS) depressants: Patients receiving other narcotic analgesics, general anesthetics, phenothiazines, other tranquilizers, sedative-hypnotics, or other CNS depressants (including alcohol) concomitantly with Empirin with Codeine may exhibit an additive CNS depression. When such combined therapy is contemplated, the dose of one or both agents should be reduced.

Use in pregnancy: Safe use in pregnancy has not been established relative to possible adverse effects on fetal development. Therefore, Empirin with Codeine should not be used in pregnant women unless, in the judgment of the physician, the potential benefits outweigh the possible hazards.

PRECAUTIONS:

Head injury and increased intracranial pressure: The respiratory depressant effects of narcotics and their capacity to elevate cerebrospinal fluid pressure may be markedly exaggerated in the presence of head injury, other intracranial lesions or a pre-existing increase in intracranial pressure. Furthermore, narcotics produce adverse reactions which may obscure the clinical course of patients with head injuries.

Acute abdominal conditions: The administration of Empirin with Codeine or other narcotics may obscure the diagnosis or clinical course in patients with acute abdominal conditions.

Allergic: Precautions should be taken in administering salicylates to persons with known allergies: patients with nasal polyps are more likely to be hypersensitive to aspirin.

Special risk patients: Empirin with Codeine should be given with caution to certain patients such as the elderly or debilitated, and those with severe impairment of hepatic or renal function, hypothyroidism, Addison's disease, prostatic hypertrophy or urethral stricture, peptic ulcer, or coagulation disorders.

ADVERSE REACTIONS: The most frequently observed adverse reactions to codeine include light-headedness, dizziness, sedation, nausea and vomiting. These effects seem to be more prominent in ambulatory than in nonambulatory patients and some of these adverse reactions may be alleviated if the patient lies down. Other adverse reactions include euphoria, dysphoria, constipation, and pruritus.

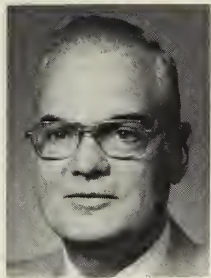
The most frequently observed reactions to aspirin include headache, vertigo, ringing in the ears, mental confusion, drowsiness, sweating, thirst, nausea, and vomiting. Occasional patients experience gastric irritation and bleeding with aspirin. Some patients are unable to take salicylates without developing nausea and vomiting. Hypersensitivity may be manifested by a skin rash or even an anaphylactic reaction. With these exceptions, most of the side effects occur after repeated administration of large doses.

DOSAGE AND ADMINISTRATION: Dosage should be adjusted according to the severity of the pain and the response of the patient. It may occasionally be necessary to exceed the usual dosage recommended below in cases of more severe pain or in those patients who have become tolerant to the analgesic effect of narcotics. Empirin with Codeine is given orally. The usual adult dose for Empirin with Codeine No. 2 and No. 3 is one or two tablets every four hours as required. The usual adult dose for Empirin with Codeine No. 4 is one tablet every four hours as required.

DRUG INTERACTIONS: The CNS depressant effects of Empirin with Codeine may be additive with that of other CNS depressants. See WARNINGS.



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QUESTIONS - ANSWERS

WILLIAM C. McCORMACK,
M.D.
AMES, IOWA

1981 SCIENTIFIC SESSION

Dr. McCormack, is program chairman for the 1981 IMS Scientific Session. He comments here on the 1981 program which is scheduled for June 24-26 at Alameda Plaza, Kansas City, Missouri.

What brief comments do you have regarding the 1981 IMS Scientific Session?

The program is designed to give *practical* information about *everyday* problems. The first session deals with problems resulting from divorce; the second session will cover old and new antibiotics and cardiovascular drugs; the third session reviews what can be learned from ultrasound, CAT scanning and radionuclides.

What are some of the 1981 program topics?

Among the 1981 topics are — What Can Be Expected From Divorce Counseling? Marriage Contracts — The Usual Implied vs. The Individual Premarital Contract; The Children of Divorce; Antibiotics Old and New; The Uses of Cardiovascular Drugs; Ultrasound; CAT Scan, and Radionuclides.

How many hours of Category I CME Credit can be earned?

The program has been approved for 11 credit hours in Category I of the AMA Physician's Recognition Award and also for 11 hours of prescribed credit by the American Academy of Family Physicians.

Why should an Iowa physician consider attending this session when there's a lot of CME to choose from?

This is a nuts and bolts program dealing with the stickier problems of everyday practice rather than the esoteric ramifications of the sometimes seen disease. We asked physicians what problems bothered them most and designed the program accordingly.

Does the program include presentations for various specialties?

Yes. Patient problems and diagnostic information to be presented (are those which come up daily) in almost all specialties. We have attempted to appeal to a broad range of interest and at the same time make available as much practical information as possible.

Will there be time for extracurricular activities?

Yes. The programming is from 8 a.m. to noon daily. In addition to the Scientific Session, planned activities include a "get acquainted" reception Tuesday evening; a special reception to be hosted by the Iowa Medical Political Action Committee on Wednesday evening; and a reception/banquet Thursday evening.

What special tourist attractions are in the area?

The area contains Kansas City's finest in shops, restaurants, theaters, all within a three-block walking distance from the hotel. Other special tourist attractions are the Nelson Art Gallery, Truman Library, Kansas City Zoo, and Worlds of Fun. This is a good opportunity to combine several days of enjoyable recreational activity with a high quality CME program.

How do physicians register to attend the 1981 IMS Scientific Session?

A registration form appears on page 193 in this issue of the JOURNAL.

THINGS YOU SHOULD KNOW

POSTPONE RULES

Activation of minimum practice standards for RN's and LPN's has been delayed by the Iowa Administrative Rules Review Committee. These rules of the Iowa Board of Nursing Examiners were to have gone into effect in May. The ARRC has delayed any action for 70 days with the indication that postponement could occur until or beyond the 1982 legislative session. Included in the rules are provisions to restrict LPN's from dispensing and to limit RN's to the dispensing of a 48-hour supply of pre-packaged and pre-labelled medication. The IMS has submitted a position paper on the proposed rules.

LICENSE/CME RENEWAL

The April mailing of license renewal applications (with revised CME report forms) has brought a favorable reaction from Iowa physicians, according to the Board of Medical Examiners. The new and simplified continuing education forms are working well. Deadline for the return of these items to the BME is May 31.

UTILIZATION STUDY

The patient day utilization study planned by the Iowa Voluntary Cost Containment Committee (IVCCC) moved forward in April. At an April meeting the IVCCC approved preliminarily the research consultant and data collector/processor to be used. It is hoped the study can begin by July 1. The IMS has given approval to this point.

COST OF CARE COMMISSION

Announcement came in May of the appointment of a new Governor's Commission to Study Health Care Costs. This further attempt to consider health care economics is to be undertaken by an 11-member group named by Governor Ray. Melvin Henderson, vice-president, Simpson College, and Duane Heintz, manager, health care services, Deere and Company, are to be chairman and vice-chairman, respectively, of the Commission. An IMS rep is expected to be among the remaining Commission members.

CHALLENGE PHARMACY REG

A new state regulation precluding pharmacists from working in physician-owned pharmacies has been challenged in Polk County District Court by four pharmacists and four medical clinics. The rule has been invoked by the State Board of Pharmaceutical Examiners. The April petition was filed to seek an injunction against its enforcement.

MAYTAG IFMC AFFILIATE

6,000 salaried employees of Maytag came under the private review program of the Iowa Foundation for Medical Care in April. The Maytag program, provided through Prudential, is the eighth entity to come under the IFMC private review.

IHSA CURTAILMENT

The Iowa Health Systems Agency is reducing its professional staff by almost half this month to stay within a pared budget. The previous 27-member staff reportedly is being cut back to 14 health planners and three secretaries.

HOSPICE ORGANIZATION

Formation of a statewide organization of Iowa hospices was started in Des Moines at an April Conference. Local hospice programs are active or are forming in various Iowa communities.

MEMBERSHIP CONTINUES STRONG

1981 IMS membership remains at a level ahead of recent years. The number of active members as of March's end stood at 2,394, ahead of the preceding year by 37. The total Society membership in all categories had reached 3,059.

Subarachnoid Hemorrhage: An Unusual Presentation of Infective Endocarditis

KENNETH RAPPAPORT, D.O., F.A.C.P.

Des Moines, Iowa

INFECTIVE ENDOCARDITIS may present in the classical way with fever, a changing heart murmur and peripheral signs of embolic phenomenon. Several published articles set forth the common symptoms of this entity, as well as the subtle features that lead one to the correct diagnosis. Fever of undetermined origin, petechiae, thrombocytopenia, splenomegaly, hematuria, Roth spots, arthritis, clubbing, splinter hemorrhages are all well known protean manifestations of endocarditis.¹ The neurological associations of infective endocarditis, i.e., brain abscess, mycotic aneurysm, vasculitis and stroke (embolic), have been well described.² As the initial manifestation of endocarditis, however, neurological signs and symptoms occur less frequently and usually do not lead one toward the correct diagnosis.³

Dr. Rappaport is in private practice in Des Moines, Iowa, specializing in internal medicine and nephrology.

This is a brief discussion of a patient who appeared with a spontaneous subarachnoid hemorrhage as the presenting sign of infective endocarditis. Suggested is the need to consider unexplained neurological signs or symptoms in considering the diagnosis.

CASE REPORT

The following case report is about a patient who appeared with a spontaneous subarachnoid hemorrhage as the presenting sign of infective endocarditis.

The case highlights are as follows:

A 41-year-old, semi-comatose, caucasian male was brought to the emergency room at Mercy Hospital Medical Center, November 11, 1975. He had complained of a headache for 48 hours prior to admission. On the morning of admission he had excruciating pain with the feeling of "something bursting" in his head. This was followed by jerking movements of his right arm and leg, followed by a comatose state in 30 minutes.

He had been in good health. There was no history of rheumatic fever, heart murmur, di-

THE SCANLON MEDICAL FOUNDATION/IOWA MEDICAL SOCIETY HAS DESIGNATED THIS ARTICLE
AS THE HENRY ALBERT SCIENTIFIC PRESENTATION FOR THE MONTH OF MAY 1981.

abetes or hypertension. No recent dental surgery had been performed.

His temperature was 37.5° C, BP = 114/80 mm Hg, pulse 92, respirations 24. He was responsive to painful stimuli only and no focal neurological signs were present. Nuchal rigidity was present. Fundi were normal, Babinski was negative bilaterally and reflexes were equal bilaterally. The cardiac rhythm was regular and no murmur was heard. No liver or spleen enlargement was detected. A puncture wound with purulent discharge was noted on his left forearm on the third hospital day, the cause of which was undetermined.

A lumbar puncture revealed grossly bloody fluid with an initial pressure of 240 mm Hg and closing pressure of 160 mm Hg. There were 530,000 RBC's and 1600 WBC/cu mm with 80% neutrophils. A gram stain of cerebral spinal fluid was negative. The protein was 84 mg % and sugar was 75 mg %. Total CSF fluid removed was 25 ml.

The WBC was 12,800 with 85% neutrophils. The Hgb was 16.0 gms %, Hct was 48. PT, PTT, platelets, F.D.P. were normal as were electrolytes and BUN; blood sugar was 204 mg %. ABG = pH 7.44, pCO₂ = 40, pO₂ = 84. EKG was normal. Chest x-ray was normal and a urinalysis of catheterized urine was clear. A radionuclide brain scan showed a "mass effect" in the left cerebral hemisphere. An X-ray of the skull was normal. The carotid angiogram showed marked spasticity of the carotid system on the left with a mass effect and leakage of dye near the left middle cerebral artery consistent with a ruptured aneurysm of an infectious etiology.

The patient was admitted to the medical intensive care unit and started on Aldomet^R, Dexamethasone, Mannitol and Amicar^R.

On the second hospital day the patient developed a right Babinski reflex and had a respiratory arrest requiring endotracheal intubation. On the third hospital day, a test for rheumatoid factor was negative. The temperature spiked to 39° C. A urinalysis revealed 15-20 RBC's/H.P.F. A right hemiparesis was present but the patient was responsive to commands. Petechiae were present on the trunk and blood cultures subsequently were positive for staph aureus (coagulase positive). No murmur was appreciated on exam. The patient was started on Methicillin 8 gms/day.

On the fourth hospital day a Grade III/VI mid systolic murmur was heard at the apex and left axilla. An echocardiogram confirmed the presence of mitral insufficiency.

The patient was dismissed on the sixtieth hospital day, alert and oriented with residual right hemiparesis and minimal mitral insufficiency. The course of Methicillin was completed and further prophylaxis recommended. The family declined cardiac catheterization. The patient was subsequently lost to follow-up.

DISCUSSION

Mycotic aneurysms are not infrequent complications of infective endocarditis and have been known to occur in the brain, abdominal aorta, sinus of valsalva, ligated ductus arteriosus and superior mesenteric, splenic, coronary and pulmonary arteries.⁴ The ruptured blood vessel usually heralds the onset of symptoms at which time the syndrome of subarachnoid hemorrhage occurs.²

Although the aneurysm may occur early in the course of endocarditis, it has been known to occur as late as years after the treatment of the valvular infection.⁵ Presenting findings have less frequently included spontaneous subarachnoid hemorrhages due to mycotic aneurysm rupture.^{2, 5} According to Roach *et al*,⁵ rupture of a cerebral aneurysm caused by microorganisms is a rare cause of subarachnoid hemorrhage. In one series reported from the Mayo Clinic, neurological findings were detected in 60% (65 of 110) of patients with endocarditis as either the chief complaint or one of the major presenting symptoms.⁶ Rupture of a mycotic aneurysm was assumed to be the primary cause in 11 patients. Similar statistics were reported by McDonald and Korb⁷ who detected cerebral aneurysms due to endocarditis in 70 of 1125 cases revealed in 1938.

In the case presented, the primary site of infection was not clearly determined. There was a skin lesion with purulent drainage on the left forearm from a puncture wound that occurred approximately 3 weeks earlier. Dental examination was normal and no prior history of rheumatic fever was known. The puncture wound was positive for staph aureus but was not detected until the third hospital day. Presumably, this was the portal of entry of the organism for the development of bacteremia and endocarditis.

In conclusion, the absence of a fever, heart murmur, or other peripheral findings does not exclude the diagnosis of endocarditis. The presence of unexplained neurological signs or symptoms should alert one to consider endocarditis in the differential diagnosis since prompt treatment is essential.

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A Point of View

HOSPITAL COSTS

MEDICAL CARE in this country, particularly hospital care, costs too much. We know that to be the case because it said so in the DES MOINES REGISTER AND TRIBUNE. Also, Jimmy Carter said it was so. In reflecting on that, it is worth bearing in mind that even broken clocks are right twice a day; and it would be difficult to deny that hospital costs are high. The alleged reason for the big hospital bills, over and above the expense of modern equipment, is that doctors admit too many patients to the hospital, keep them there too long, order too many tests, and do too much surgery, a good percentage of which is probably unnecessary. The solution, of course, is to change the system and control the doctors — the villains in the piece.

But hold up! A strange thing happened here in Des Moines. Someone made a study of the high cost of care at Broadlawns-Polk County Hospital and, according to the newspaper, concluded that the high cost was due to poor administration. This then raises a question: Should we not, in evaluating hospital costs, look past the doctor for a change and consider the hospital administration?

There is an old adage (and if there isn't, there should be) that if you have a lot of administrators, there will be a lot of paper work; and if there is a lot of paper work, you will have a lot of administrators; and so on. We should all take stock. Bureaucracies, private as well as public, grow and grow and ultimately become

top-heavy unless restrained. One of the clear signals from the recent landslide election of Ronald Reagan was that almost everybody is fed up with redundant rules, regulations, and unnecessary, even foolish, paper work. Let me give you an example of what can happen.

I have heard of a hospital where a care assessment form must be completed by a nurse *every day on every patient*. It would be extremely difficult to adequately describe the form without going into too much detail, but if you saw it, you still wouldn't believe it. Suffice it to say that 48 nursing functions are listed, divided under 7 headings. Illustrative of the headings are "respiratory aids," "elimination," "physical hygiene," while examples of the nursing functions are "Bath (Self 1.0) (Assist 2.5) (Complete 4.5)," "Diapers/Bedpan/Urinals (1.0)," "Dangle with assistance (2.0)." The figures in parentheses represent numerical values of the specific nursing functions, and the appropriate calculations are entered on the form. Entries for each patient are made every day by nurses on the 7 a.m.-3 p.m. shift. The nurses actually complete the individual patient entries for the entire 24 hours, making a projection of what functions will be performed by nurses on the following 2 shifts. The 3-11 nurses, however, may have an opportunity to change the entries and calculations if the projected values are inadequate. The figures when completed go into a computer. The time necessary to conscientiously complete the entries on each patient has been estimated to be from 5 to 10 minutes. Let us assume a general average of 7 minutes per patient. In a 500 bed hospital, that would

(Please turn to page 209)

Physician Involvement In Health Planning — 1981

JOHN E. TYRRELL, M.D.

Manchester, Iowa

Odds are that government's role in health planning will diminish in the new political environment. Still the need for conscientious consideration of health care needs will go on. The responsibility is apt to be more community based and more voluntary. The involvement of physicians is most vital.

HEALTH PLANNING legislation may have been intended to promote local efforts to assure quality . . . accessibility . . . and availability. But it has become increasingly a system of mandated quotas — referred to as guidelines — designed to ration health services and limit government cash outlays.

The current health planning process poses many problems for medicine. It is the nature of physicians to orient themselves to the patient and his disease process. In this context, the quality of care delivered is regarded as uniformly good among those patients served.

The criticism which emanates generally from the politicians and the planners has to do with those citizens who do not avail them-

selves of the health care that is fragmented. Health planners yearn for a system that will guarantee life-long access to health care for every citizen. On top of this, physicians are being asked to move into more programs of disease prevention. We are also told that as physicians we are responsible to assure patient compliance with regimens of treatment once they are initiated.

We are accused of practicing crisis medicine rather than preventing disease. We are expected to convince people that significant life style changes are necessary to assure reaching an optimum longevity.

WHERE TO START

When the physician is faced with these conflicts, it is difficult to know where to start. The local community is the obvious place, but it is difficult to make the transition from the delivery of personal patient care to involvement in the broad community aspects of health planning. It also necessitates hard work, long hours . . . dedication . . . and a willingness to spend time away from the practice if a physician is to engage in health planning.

In health planning, a physician must learn to work with many elements of the community. He must begin to appreciate that increasing health care costs are becoming a mounting concern to local industry. He must appreciate the demands on the working man to modify his salary askings in recognition of the large fringe benefits which include health care coverage.

The physician must appreciate the commu-

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nity pride associated with the local hospital(s). For many communities the hospital represents a key industry and source of employment. The physician must know that people want to go to a facility that is close at hand. People want a doctor and a hospital available immediately even in sparsely populated areas. This is true even though circumstances suggest otherwise. The physician planner must study and recommend the appropriate use of paramedical personnel to augment and increase the availability of health care.

Even as the physician works within his community to assure good local health planning, he is faced with the formidable challenge of complying with present day government health planning laws. The laws have prompted considerable consternation among physicians with their burdensome regulations, the uneven application, the massive amounts of paper, the complicated bureaucratic structures and procedures and all of the associated problems.

It is frustrating for physicians to spend hours and days in meetings concerned with the form of health planning, rather than the substance. It is frustrating for physicians to serve on committees that continuously debate the composition of the planning board. Often more time is spent debating the size and structure of the health plan rather than its contents. It is overwhelming for physicians to be presented with massive documents setting forth utopian programs which look wonderful on paper, but are either too expensive or too broad to use in responding to the health needs of our communities.

GOOD PHYSICIAN PARTICIPATION

It is to their credit that some 6,000 physicians continue to work at all levels of the health planning process in spite of these frustrations. They continue to monitor HSA, SHCC and SHPDA activities. They are providing information to their colleagues and assisting their fellow physicians in understanding the nature of health planning. They have succeeded in making sure the health planning that is being done is as effective as possible under the circumstances. These thousands of physicians have been aided by more than 30 full-time planning staffs within state medical societies. Physicians on special task forces have used their expertise to add depth and validity to health planning.

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Each gram of Anusol-HC Cream contains hydrocortisone acetate, 5.0 mg; bismuth subgallate, 22.5 mg; bismuth resorcin compound, 17.5 mg; benzyl benzoate, 12.0 mg; Peruvian balsam, 18.0 mg; zinc oxide, 110.0 mg; also contains the following inactive ingredients: propylene glycol, propylparaben, methylparaben, polysorbate 60 and sorbitan monostearate in a water-miscible base of mineral oil, glyceryl stearate and water.

Anusol-HC Suppositories and Anusol-HC Cream help to relieve pain, itching and discomfort arising from irritated anorectal tissues. These preparations have a soothing, lubricant action on mucous membranes, and the antiinflammatory action of hydrocortisone acetate in Anusol-HC helps to reduce hyperemia and swelling.

The hydrocortisone acetate in Anusol-HC is primarily effective because of its antiinflammatory, antipruritic and vasoconstrictive actions.

Indications and Usage: Anusol-HC Suppositories and Anusol-HC Cream are adjunctive therapy for the symptomatic relief of pain, itching and discomfort in: external and internal hemorrhoids, proctitis, papillitis, cryptitis, anal fissures, incomplete fistulas, pruritus ani and relief of local pain and discomfort following anorectal surgery.

Anusol-HC is especially indicated when inflammation is present. After acute symptoms subside, most patients can be maintained on regular Anusol-HC Suppositories or Ointment.

Contraindications: Anusol-HC Suppositories and Anusol-HC Cream are contraindicated in those patients with a history of hypersensitivity to any of the components of the preparations.

Warnings: The safe use of topical steroids during pregnancy has not been fully established. Therefore, during pregnancy, they should not be used unnecessarily on extensive areas, in large amounts or for prolonged periods of time.

Precautions: General: Symptomatic relief should not delay definitive diagnoses or treatment.

Prolonged or excessive use of corticosteroids might produce systemic effects.

If irritation develops, Anusol-HC Suppositories and Anusol-HC Cream should be discontinued and appropriate therapy instituted.

In the presence of an infection the use of an appropriate antifungal or antibacterial agent should be instituted. If a favorable response does not occur promptly, the corticosteroid should be discontinued until the infection has been adequately controlled.

Anusol-HC is not for ophthalmic use.

Pregnancy

See "WARNINGS"

Pediatric Use

Care should be taken when using the corticosteroid hydrocortisone acetate in children and infants.

Dosage and Administration: Anusol-HC Suppositories—

Adults: Remove foil wrapper and insert suppository into the anus. Insert one suppository in the morning and one at bedtime for 3 to 6 days or until inflammation subsides. Then maintain comfort with regular Anusol Suppositories.

Anusol-HC Cream—Adults: After gentle bathing and drying of the anal area, remove tube cap and apply to the exterior surface and gently rub in. For internal use, attach the plastic applicator and insert into the anus by applying gentle continuous pressure. Then squeeze the tube to deliver medication. Cream should be applied 3 or 4 times a day for 3 to 6 days until inflammation subsides. Then maintain comfort with regular Anusol Ointment.

NOTE: If staining from either of the above products occurs, the stain may be removed from fabric by hand or machine washing with household detergent.

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They have been able to bring a more rational perspective to the reams of paper that have been presented to them. The continued involvement of physicians in health planning is particularly important at this time when the future of the present law is in doubt.

It is possible the health planning law as we know it may not be renewed. If this happens it will not mean that health planning should be abandoned. It will mean that government has concluded that the regulatory approach as imposed at the federal level is not necessary. If this occurs it will be important for medicine to reevaluate what health planning is and where it is going.

More physicians are needed to join the great debate about how health care is to be provided. It is encouraging to see scholarly articles on this subject in respected medical journals. Thoughtful speeches are being given by physicians to their peers and community organizations.

Nonetheless, there is concern among health planning leaders outside of medicine that not enough physicians have been allowed to contribute their important expertise under the present legislation. Industry leaders are paying more each year for the health care of their employees. They are looking to us for help and leadership. Labor leaders are teaming with industry looking for ways to stretch their health care dollars. Heads of hospitals and long term care facilities are well aware that it is the physician who writes the order for the care given in their institutions. Legislators are searching for better ways of allocating those federal dollars spent for health care. It is becoming increasingly clear that physicians must do a better job in helping to provide solutions to these problems.

HARD DECISIONS AHEAD

While it is too early to predict the precise direction the new administration will follow, we can reasonably assume the public must be prepared to accept some hard decisions. There is apt to be a reduction in overall health spending as a balanced budget is sought. It may be that the health planning legislation, as we know it, will be expendable. Repeal is popular with physicians. But repealing the health planning laws will not make the problems of increasing costs go away.

Our society has come to expect comprehensive health services to be available. This means providing a greater number of units of medical service to a greater number of people. Technology and research will bring more sophisticated and costly diagnostic and treatment equipment. Keeping well equipped modern facilities up to date will be expensive.

First dollar coverage has lessened the incentive of patients to use less costly services or to prudently limit the number of services that are really needed. So as we look at the problem of increasing costs, how willing are we to become intelligent and concerned stewards of our patients' health care dollars? At this moment of national indecision physicians have a rare opportunity to become actors on the stage . . . rather than critics of the performance. How ready are we to become actors on this stage where decisions are to be made as to how large will be the investment of government in health care? Does anyone really believe that government alone can do it better? Is more regulation the answer?

Is it up to a health care czar or some committee in Washington to reduce bed capacity, close hospitals, ration the number of physicians and decide where they should practice?

HEALTH CARE DEBATE

There are many voices being raised in the debate over health care. There are powerful forces at work which must be reconciled to assure that individuals are able to get quality care and appropriate health education in a timely manner and at a reasonable cost.

Now more than ever, physicians must provide effective leadership at all levels of health planning. Admittedly, physicians are busy with patient care, continuing education, hospital staff obligations, and other professional responsibilities. But, somehow, more time must be found to implement Article VII of the AMA Principles of Medical Ethics. I quote, "A physician shall recognize a responsibility to participate in activities contributing to an improved community."

Good community based health planning has to be our first priority. Physicians must continue to work with and support others in the community who are working for good total health care. The local medical society must relate to the community which it serves much as

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a doctor does to his patient, with understanding, concern and good care.

Even the best physician cannot cure all of his patients' ills. Many times it is helping patients to cope with disability and aging and chronic illness that is the real test of the physician's skills. So must the local medical society work with its community to assure the best health care available within the resources of the community. Beyond the local community level, physicians must work to assure that state and federal legislation supports rather than interferes with good community based health planning.

ORGANIZATION INVOLVEMENT

Again, more than ever before state medical societies must support good health planning. Physicians must contribute at the state level. State medical societies must provide staff time and expertise to help these physicians to be knowledgeable and effective. State medical societies must stand ready to help their local medical societies in implementing good voluntary locally based planning.

At the national level, the American Medical Association continues to monitor the health

planning process. Its ad hoc committee on health planning has been specifically charged to serve as a resource and strategy center, available to help individual physicians and medical societies involved in planning. At this time the committee is working on the most recent directive from our House of Delegates to develop strong physician leadership at the community level.

In the debate over health care the voice of organized medicine must advocate sound community health planning. We must speak with conviction, demonstrate an understanding of the problems and a willingness to work to solve them. We have seen what hard work and dedication can do to change the political climate of our nation. Government is being challenged by its citizens who want less regulation and forced planning.

As physicians, we have a rare opportunity to exert greater leadership in the health planning field. No one needs to remind us of what the alternatives are. The time is now. You are medicine's leaders. You must carry this message back to your communities. You hold the key to medicine's future.

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CONTRAINDICATIONS: Advanced arteriosclerosis, hyperthyroidism, known hypersensitivity, or idiosyncrasy to the sympathomimetic amines, glaucoma. Agitated states. Patients with a history of drug abuse. During or within 14 days following the administration of monoamine oxidase inhibitors, (hypertensive crises may result).

WARNINGS: If tolerance develops, the recommended dose should not be exceeded in an attempt to increase the effect; rather, the drug should be discontinued. Tenuate may impair the ability of the patient to engage in potentially hazardous activities such as operating machinery or driving a motor vehicle; the patient should therefore be cautioned accordingly. **Drug Dependence:** Tenuate has some chemical and pharmacologic similarities to the amphetamines and other related stimulant drugs that have been extensively abused. There have been reports of subjects becoming psychologically dependent on diethylpropion. The possibility of abuse should be kept in mind when evaluating the desirability of including a drug as part of a weight reduction program. Abuse of amphetamines and related drugs may be associated with varying degrees of psychologic dependence and social dysfunction which, in the case of certain drugs, may be severe. There are reports of patients who have increased the dosage to many times that recommended. Abrupt cessation following prolonged high dosage administration results in extreme fatigue and mental depression; changes are also noted on the sleep EEG. Manifestations of chronic intoxication with anorectic drugs include severe dermatoses, marked insomnia, irritability, hyperactivity, and personality changes. The most severe manifestation of chronic intoxications is psychosis, often clinically indistinguishable from schizophrenia. **Use in Pregnancy:** Although rat and human reproductive studies have not indicated adverse effects, the use of Tenuate by women who are pregnant or may become pregnant requires that the potential benefits be weighed against the potential risks. **Use in Children:** Tenuate is not recommended for use in children under 12 years of age.

PRECAUTIONS: Caution is to be exercised in prescribing Tenuate for patients with hypertension or with symptomatic cardiovascular disease, including arrhythmias. Tenuate should not be administered to patients with severe hypertension. Insulin requirements in diabetes mellitus may be altered in association with the use of Tenuate and the concomitant dietary regimen. Tenuate may decrease the hypotensive effect of guanethidine. The least amount feasible should be prescribed or dispensed at one time in order to minimize the possibility of overdosage. Reports suggest that Tenuate may increase convulsions in some epileptics. Therefore, epileptics receiving Tenuate should be carefully monitored. Titration of dose or discontinuance of Tenuate may be necessary.

ADVERSE REACTIONS: **Cardiovascular:** Palpitation, tachycardia, elevation of blood pressure, precordial pain, arrhythmia. One published report described T-wave changes in the ECG of a healthy young male after ingestion of diethylpropion hydrochloride. **Central Nervous System:** Overstimulation, nervousness, restlessness, dizziness, jitteriness, insomnia, anxiety, euphoria, depression, dysphoria, tremor, dyskinesia, mydriasis, drowsiness, malaise, headache; rarely psychotic episodes at recommended doses. In a few epileptics an increase in convulsive episodes has been reported. **Gastrointestinal:** Dryness of the mouth, unpleasant taste, nausea, vomiting, abdominal discomfort, diarrhea, constipation, other gastrointestinal disturbances. **Allergic:** Urticaria, rash, ecchymosis, erythema. **Endocrine:** Impotence, changes in libido, gynecomastia, menstrual upset. **Hematopoietic System:** Bone marrow depression, agranulocytosis, leukopenia. **Miscellaneous:** A variety of miscellaneous adverse reactions has been reported by physicians. These include complaints such as dyspnea, hair loss, muscle pain, dysuria, increased sweating, and polyuria.

DOSEAGE AND ADMINISTRATION: Tenuate (diethylpropion hydrochloride): One 25 mg. tablet three times daily, one hour before meals, and in mid-evening if desired to overcome night hunger. Tenuate Dospan (diethylpropion hydrochloride) controlled-release: One 75 mg. tablet daily, swallowed whole, in mid-morning. Tenuate is not recommended for use in children under 12 years of age.

OVERDOSAGE: Manifestations of acute overdosage include restlessness, tremor, hyperreflexia, rapid respiration, confusion, assaultiveness, hallucinations, panic states. Fatigue and depression usually follow the central stimulation. Cardiovascular effects include arrhythmias, hypertension or hypotension and circulatory collapse. Gastrointestinal symptoms include nausea, vomiting, diarrhea, and abdominal cramps. Overdose of pharmacologically similar compounds has resulted in fatal poisoning, usually terminating in convulsions and coma. Management of acute Tenuate intoxication is largely symptomatic and includes lavage and sedation with a barbiturate. Experience with hemodialysis or peritoneal dialysis is inadequate to permit recommendation in this regard. Intravenous phenolamine (Regitine®) has been suggested on pharmacologic grounds for possible acute, severe hypertension, if this complicates Tenuate overdosage.

Product Information as of January, 1980

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References: 1. Citations available on request from Merrell Dow Pharmaceuticals Inc., Cincinnati, Ohio 45215. 2. Hoekenga, M. T. et al: A comprehensive review of diethylpropion hydrochloride. In *Central Mechanisms of Anorectic Drugs*, S. Garattini and R. Samanin, Ed., New York: Raven Press, 1978, pp. 391-404.

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COMMENTING EDITORIALY

MARION E. ALBERTS, M.D.
SCIENTIFIC EDITOR

GOVERNMENTAL CUT-BACKS

A FATHER'S INCOME ceases because of illness. Fixed expenses continue; disability income may cover those expenses. The costs of *the good life* are no longer covered by income. Shall they continue indefinitely to increase the debt of the family? Many of the extra benefits of a good income can be eliminated — at least temporarily, and perhaps permanently.

So it is with our country's current economy. There has been an illness in Washington, and now it is necessary to institute some economy measures. The run-away spending of Uncle Sam has to cease until recovery takes place. In the meantime, the entire family of our society must decrease expenditures. Some expenditures heretofore have been unadulterated wastes of money — luxuries as well.

The President has announced proposed health program cuts of more than \$2 billion. A 25% reduction in the federal contribution to 40

health and welfare programs is proposed. The federal health planning programs and the PSRO program are expected to go. Spending for HMO's is to be phased out by 1983. Seven CDC programs may be eliminated. These include venereal disease, immunization, rat control and fluoridation. Health education programs will come under the budget cutting axe as well.

There are those who will scream to the heavens about their pet projects being in jeopardy. We can rejoice in the thought that some of the restraints upon the free trade aspects of our profession will be relieved of the yoke of federal interference and restraint. Prior to all the magnanimous federal grants our society was not in such a sad state. Perhaps it is time to look back to the "good old days" and accept the good of that era and realize that progress sometimes is truly nothing more than decay and infestation of our society by greed and meddling into the affairs of a good life; and the good life is not a grant-in-aid free ride provided by the federal government.

It is time for both individual and collective concern over the good of all. Hard work and a degree of unselfishness are not harmful. Rights have to be tempered with responsibility. Our profession must cooperate in any way, as we have in many instances in the past, to assist in attaining a new posture for government — federal and state and local — for the track we have been on is leading to an undesirable destination. May the leaders of our nation deal with the entire proposition with cool deliberations, untainted by selfish desires and unwarranted rhetoric. — M.E.A.

PARENTHOOD

BECOMING A PARENT is a unique and difficult task. No other position in life is undertaken with so little expertise and preparation. The myths and old wives' tales handed from generation to generation often are the only guiding principles available to young parents.

Against this backdrop, the modern parent has become concerned about his or her role. What was the custom for grandparents no longer fulfills today's needs. The father assumes a new role for he is often married to a

working wife. He assumes new responsibilities as a husband as well as a father. Unfortunately, in some instances, the working parents assume less day-to-day responsibility, and depend on surrogate parents, e.g., day-care centers, baby-sitters, or the grandparents.

Shared parenting has become prevalent as more and more mothers take jobs outside the home. Yet, the parental duties remain unequal as statistics show the mother devoting 4 to 7 hours a day in parental and household tasks, while the father rates only 2 hours.

Fathers-to-be are now more involved in natural childbirth procedures, and are no long-



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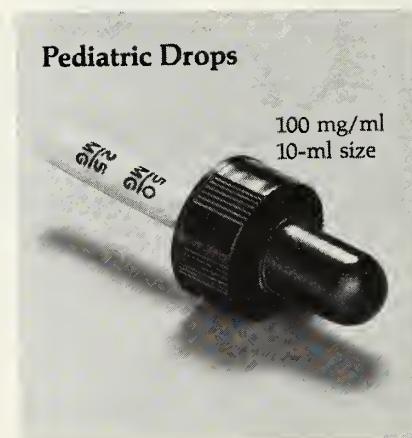
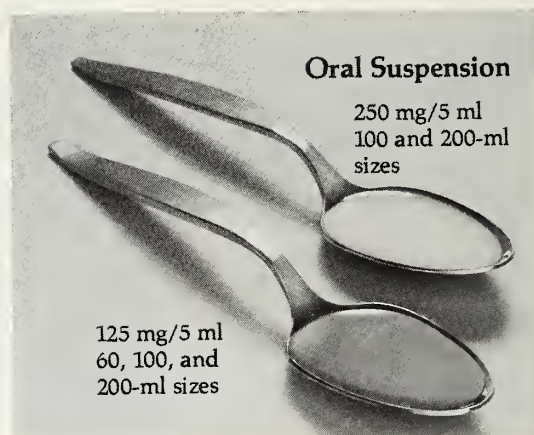
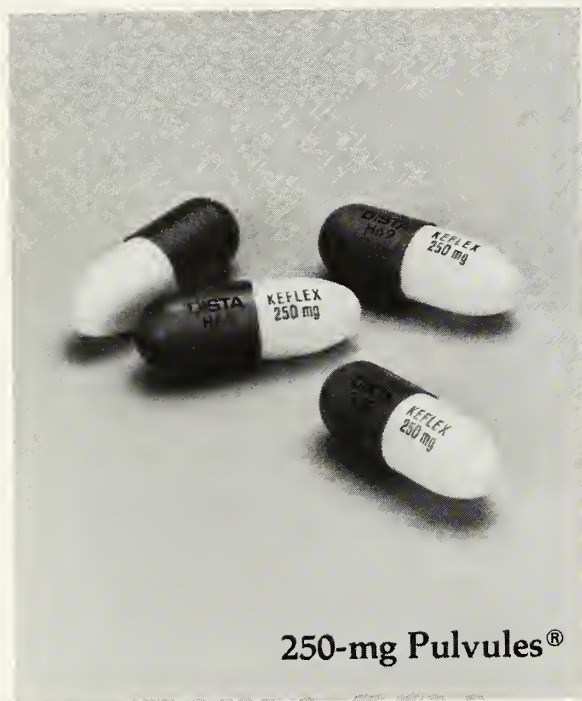


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EDITORIALS

(Continued from page 206)

er isolated from the birth-rooms and newborn nurseries. Sweden has a governmental policy allowing fathers a paternity leave. About 10% of the fathers accept this arrangement to help their spouses in returning to outside jobs.

Human fathering attitudes have varied greatly from generation to generation, as well as from culture to culture. The role of the father as the patriarchal head of the family has changed. His position has diminished as the chief provider with omnipotent power over his wife and children. It has been eroded by social and economic forces. Women's liberation has placed the father in a dual role; with that children have become more independent, because they, too, have their advocates for rights.

Studies show shared-parenting has aided children with their educations. They are apt to become involved with the interests of both the father and the mother. A realization that the father has more interest in the child's welfare has led to better academic achievement. In return, the father reaps a harvest of new delights as involvement in the child's activities renews past joys and pleasures.

Each father and mother bring unique backgrounds and experiences to their offspring. The sharing of happiness and sorrow will enhance the beauty of family life. The new way of life is good; though we must be wary of the economic drives that keep both parents more and more absent from their children. Parents must guard against material gains overshadowing the basic principles of family life — for the family is the foundation of society. Should the family become too materialistic and base, all of society shall suffer the consequences. — M.E.A.

A POINT OF VIEW

(Continued from page 199)

represent 3,500 minutes spent on completing the forms every day. That translates roughly into 7 nurses working full time in an 8 hour shift just to complete the forms — and this every day! If that continues for weeks and months, as it has, can it possibly make sense? And what of the cost?

It is said that some good comes out of everything. In this case, it must be the poem that follows — a poem that recently came to my attention. The poet, motivated by modesty, or perhaps fear, wishes to remain anonymous.

PROGRESS

*A hospital now seems to have
Executives galore
Administrators are a gas
Vice-presidents we adore*

*Nobody knows exactly what
These noble creatures do
Presumably they meet and stir
A bureaucratic brew*

*But wait — we have a sample here
Of genius on the beam*

*A detailed care assessment form
A statistician's dream*

*The patient called "Dear nurse please come
I have a problem now
If you delay, what happens then
The fault I disavow"*

*"But sir you do not understand
Cannot you even see
I'm busy with this lengthy form
It has priority"*

*The time ran out, you know the rest
Too dreadful to relate
But paper work had scored again
The form was up-to-date*

*With everybody in the act
Oh Lord our prayer don't fail
You must not tell Hippocrates
Or Florence Nightingale*

Well, friends, there you have it — a point of view. Incidentally, critics may say that the above poem is lousy poetry, but what do they know? It rhymes, doesn't it? — Daniel F. Crowley, M.D., Des Moines

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VOX DOCS

Please look below at this month's Vox Docs question. Give us your answer. Send it to IMS JOURNAL, 1001 Grand Avenue, West Des Moines, Iowa 50265. Last month's question and answer results are shown to the right with several of the comments we received printed below.

"Most physicians feel doctor/patient communication is of the greatest importance. It is an essential part of good patient care and helps in preventing malpractice claims." — *A. M. Dolan, M.D., Waterloo*

"I feel physicians tend to ignore patients and families at times either due to a lack of time or an inability to talk to a patient. This is one of the most important aspects of the 'art of medicine' and prevents malpractice claims." — *Michael Deter, M.D., Waterloo*

"Good physician-patient communication is the basis of a satisfactory relationship, and improves the patient's understanding, acceptance and compliance with a treatment program." — *Ralph R. Pray, M.D., Des Moines*

LAST MONTH'S QUESTION

What level of importance do physicians assign to doctor/patient communications in the prevention of malpractice claims?

VERY HIGH	44%
FAIRLY HIGH	28%
COULD BE MUCH HIGHER	28%

"All physicians should be open and honest and communicate well with their patients; and almost as important is that their nurses do so too." — *Richard L. Miller, M.D., Waterloo*

"Always attempt to maintain the level and quality of communication that you would appreciate yourself, as a patient, or that you would provide to a colleague patient or his family." — *Mark Ravreby, M.D., Des Moines*

"Complaints are frequently heard (from patients) that the doctor didn't tell me what was coming." — *Paul Holzworth, M.D., Des Moines*

MAY QUESTION FOR IOWA PHYSICIANS

"Physician image" was said to need priority attention by a high per cent of member physicians who answered the recent IMS opinion survey. Do you agree the traditional high public acceptance of medicine has slipped in recent years and is in need of concerted attention?

- ☐ FEEL STEPPED UP ATTENTION NEEDED
- ☐ HAVE SEEN NO SIGNIFICANT ATTITUDINAL CHANGE
- ☐ NO OPINION

Comment, please _____

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OUR MAN ON EDUCATION

RICHARD M. CAPLAN, M.D.

CME AND COMMUNICATIONS TECHNOLOGY

I RECENTLY ATTENDED a conference dealing with the potential linkage that might usefully develop, even beyond today's glut, between the world of CME and the world of communications technology. (That term encompasses, among other things, computers, micro-processors, micro- and ultrafiche, satellites, electronic publishing, etc., along with such humdrum formats as telephone, radio, and television, and for some it even includes such ancients as books and journals.) Just listening to a recital of the hardware that now exists and what it *can* do is itself mind-boggling, but the mental lid is exploded when conjecture proceeds about all it *could* do.

It didn't take the conferees long to realize that the big gap between where we are and the Utopian world where we might be is indeed not a matter of technological deficits, but again, human deficiencies (challenges, if you prefer) of two kinds: 1) Developing the software (programming, instructional packages of all kinds) is exceedingly tedious and requires a talented human who has the knowledge, motivation and time. 2) And maybe an even greater hurdle lies in overcoming the attitudinal barriers of social and psychological inertia. I could list lack of money as a third factor, but it's really an important root cause of the other

Dr. Caplan is Associate Dean for Continuing Medical Education at The University of Iowa College of Medicine.

two. The attitudinal barrier exists because full use of these new techniques would change so many deeply ingrained habits, for example, random rather than problem-oriented medical reading, dependence on our own faulty memories to nudge us about what item of history or examination is needed next or what diagnostic possibility is most likely, and reluctance to increase our dependence on machines to guide our thinking and behavior.

The new and incipient telecommunications technologies could profoundly reorganize our conception of what and who is a physician, what he or she does, and how he or she is paid. But I believe these things will come to pass. Witness the growing number of physicians who have bought electronic calculators, video playback units, office computers, and who cheerfully interact with a machine while losing to it at chess or bridge.

One major theme of the conference involved CME-ers' desire to provide education that is timely, accurate, and problem-related at the precise time and place it's most needed. That

"... Mr. Babbage, who invented the computer over a century ago, didn't live to see what it hath wrought. But it hath wrought it, nonetheless."

means one thing very clearly — having in the office and the hospital bedside or nursing station a computer that can access appropriate information and data bases of staggering diversity within seconds, and simultaneously integrate such responses with all the known information about the patient in question. Such a system is now operative at the University of Vermont and was described by its developer — the same Lawrence Weed who developed and popularized the problem-oriented medical record. I wish you, too, could have heard the fascinating presentation by that man of genius, and watched his anger flare that the world of medicine and medical education moves so slowly, if at all, toward the almost Utopian future he sees so clearly. Take heart, Dr. Weed — Mr. Babbage, who invented the computer over a century ago, didn't live to see what it hath wrought. But it hath wrought it, nonetheless.

DRUG THERAPY REVIEW



UNIVERSITY OF IOWA HOSPITALS AND CLINICS

REYNOLD SPECTOR, M.D., Editor

HIGHLY PURIFIED INSULIN

THE MAJORITY of insulins used in the near future will be purer than those to which we have become accustomed. They may also be more potent and have fewer side effects. The additional purification steps necessary in their manufacture ensure greater cost to the patient, which may be substantial. Proper utilization of these preparations requires that the physician be aware of the specific advantages of each new type. This article will review the chemistry and use of these newer insulins.

The old USP insulins were manufactured by acid-ethanol extraction of animal pancreas, followed by differential crystallization. This yielded a fairly impure product with about 40,000 parts per million (ppm) of proinsulin and many other impurities. With the introduction of "U-100" insulin, an additional purification step was added, i.e., sizing of the protein by gel filtration. U-100 insulins (called "single peak") were much lower in proinsulin (about

3,000 ppm proinsulin). The newer, recently introduced insulins undergo an additional step, i.e., purification by charge on an ion-exchange column. They are available as preparations called "improved single peak" (Iletin) insulin which are low in proinsulin (<50 ppm) and in other contaminants (pancreatic polypeptide, glucagon, somatostatin, and des-amido-insulin) and also as ultrapure preparations, sometimes called monocomponent insulins that have less than 5 ppm of proinsulin and other contaminants. These latter insulins are marketed by Lilly as Iletin II, by Novo as Actrapid, and by Nordisk as "Quick" insulin. The Novo and Nordisk preparations are not widely available in Iowa.

The "purified single peak," or Iletin insulin is replacing standard Lilly "U-100" preparations in pharmacies and bears the word "NEW" in red across its label. Lilly is no longer producing single peak insulin, and it will no longer be available when current supplies are depleted. The new Iletin insulins will be available in the same forms as the older Lilly insulins and should be used in the same manner. Although there are no major published studies using this particular insulin, there is evidence to suggest that a dosage reduction will be required in some patients. The magnitude of this reduction may be as large as 20-30%. Thus, after switching insulins, it is reasonable to monitor closely the dosage (particularly in insulin-dependent diabetics) and adjust it as necessary over a period of 3-7 days. In other patients a dosage increase is required. The reasons for these alterations in dosage are unclear. We can expect almost all diabetics to be using Iletin (improved single peak) insulin within the next few months. The use of monocomponent insulins should be more restricted. Although it was initially hoped that monocomponent insulin would not be immunogenic, in practice most patients treated with monocomponent insulin still develop antibodies to insulin. The titer developed on the monocomponent insulin is only about one-half of that developed on less pure insulins. However, patients that develop antibodies while on USP insulin do not decrease their titers when switched to monocomponent insulin. Insulin antibodies seem to be deleterious in two ways: (1) the rare situation in which high affinity antibodies can cause serious insulin resistance; and (2) the more common

This information for Iowa physicians is furnished and sponsored by the University of Iowa Hospitals and Clinics.

situation in which low affinity antibodies act as insulin binding proteins and prolong the action of insulin. This latter problem is not usually a significant clinical problem.

At this time there appear to be 3 major indications for monocomponent insulin: (1) lipodystrophy, (2) insulin resistance due to anti-insulin antibodies, and (3) insulin allergy. Lipodystrophy may be manifest as lipoatrophy or lipohypertrophy. Lipoatrophy is characterized by the unsightly local loss of subcutaneous fat in the area in which insulin has been injected. The monocomponent insulins appear to have a dual role in the treatment of this condition. Lipoatrophy has not been reported to occur in patients using monocomponent insulin and thus patients switching to one of the purer insulin preparations will have no further accumulation of these lesions. In addition, injections of monocomponent insulin into the margin of such lipoatrophic regions leads to the reaccumulation of adipose tissue and the restoration of normal appearance of the region. In a few anecdotal reports, the use of monocomponent insulin has reduced the fatty buildup or lipohypertrophy occasionally seen at the sites of insulin injection. The use of purer insulin for this latter state needs further study.

Another major use for the purer insulins appears to be in patients with severe insulin resistance due to anti-insulin antibodies. Humans form antibodies to both porcine insulin (which differs from human insulin in only a single amino acid) and beef insulin (which differs in 3 amino acids). The latter is much more immunogenic. Many patients with severe, antibody mediated, insulin resistance (requiring greater than 100 units/day) will have dramatic reductions in their insulin requirement upon initiation of monocomponent porcine insulin.

A small group of patients demonstrate an allergy to insulin. These may be either systemic or local. The allergy may be due to either the beef or pork component of mixed insulin preparations, or it may be due to both. Skin testing can separate these conditions, and a kit is available from the Lilly Company to perform this. Patients with local reactions, whether immediate or delayed in type, should be switched to monocomponent insulin of the type to which they do not demonstrate sensitivity. This will result in improvement in great-

er than 70% of cases. Local sensitivity to insulin of both species can be treated with local injection of antihistamines. Systemic reactions to insulin are more serious. If the patient does not react to one species of insulin, this obviously should be used (as the monocomponent form). A patient reacting to both species will require desensitization.

In summary, physicians now have available a series of highly purified insulins. Most patients should be switched to the "purified single peak" or NEW Iletin insulin. This is considerably purer than USP or single peak and should result in a lower incidence of side effects. These insulins should cost the patient \$4-6 per 1,000 units. The monocomponent insulins, most widely available as Iletin II, should cost the patient \$11-15 and should be used for patients with lipodystrophy, severe insulin resistance or insulin allergy. It is also reasonable to use these ultrapure insulins in patients who will only require it for short periods, i.e., surgery or pregnancy. Some patients may wish to use the more purified insulins, in spite of their cost, because of the lower incidence of induction of anti-insulin antibodies. — *Barry H. Ginsberg, M.D., Ph.D., Assistant Professor of Medicine and Biochemistry, University of Iowa Hospitals.*

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STATE DEPARTMENT/ PUBLIC HEALTH

MORE HEALTH PLANNING INFO

These views and opinions on health planning have been prepared by Cooper L. Parker, Director, Office for Health Planning and Development, Iowa State Department of Health.

THERE IS APPARENTLY nothing so subject to the winds of change as health planning. At its end the Carter administration questioned seriously the effectiveness of local health planning as established by present law. The proposal was to cut drastically the appropriation to the health systems agencies. The argument was that capital expenditure limitations on hospitals, coupled with the encouragement of the development of health maintenance organizations would diminish the rise in health care costs. The position of the Reagan administration on health planning is not dramatically different from the Carter administration. The only difference seems to be in the speed with which the present structure is to be dismantled.

The plan is to defund the health systems

This information on public health matters is furnished and sponsored by the Iowa State Department of Health.

agencies by half this year, to remove all funding next year, and to eliminate funding for the state health planning and development agencies the following year. David Stockman, director, Office of Management and Budget, argues within 2 years the health delivery system in this country will be on a firm competitive footing. That position has little support in the Congress, and less support among those who have promoted competitive models. However, it remains that there is equally little support for the HSAs. There are those who believe because the states will remain on the scene for an additional year after the HSAs disappear this means the administration is sensitive to the criticisms of its timetable. If it still appears, 2 years down the line, that it will take many more years to assure the influence of the market and competitive forces in this industry, Congress and the administration will have the option of leaving the state agencies intact for as long as necessary.

STATE AUTHORITY

Another factor to be considered in assessing the future is the return of authority to the states. This administration is committed to removing virtually every federal regulation, and returning that regulatory authority to the individual states. In fact, the justification for the reduction in funding to programs to be included under the so-called "block grant" is the curtailment of federal regulation, with the consequent reduction in the money necessary for state and local governments to achieve compliance with those regulations.

The question becomes, "What will planning be under the Reagan Administration?" It is not possible to answer with certainty; however, it is possible to lay out certain expectations.

1. We can expect changes in the way we regulate and in the things we regulate. I would expect the financial threshold for certificate of need will be raised significantly. In addition, I believe the states will be given the flexibility to write regulatory programs that fit their own individual needs. It is possible states that meet definite cost criteria may be exempted from certificate of need. In short, we can expect to see a continued monitoring of capital expenditures over the next 2 to 5 years, but that monitoring will be significantly different from the present CON legislation.

(Please turn to page 219)

Examine Me.

During the past several years, I have heard my name mentioned in movies, on television and radio talk shows, and even at Senate subcommittee sessions. And I have seen it repeatedly in newspapers, magazines, and yes, best-sellers. Lately, whenever I see or hear the phrases "overmedicated society," "overuse," "misuse," and "abuse," my name is one of the reference points. Sometimes even *the* reference point.

These current issues, involving patient compliance or dependency-proneness, should be given careful scrutiny, for they may impede my overall therapeutic usefulness. As you know, a problem almost always involves improper usage. When I am prescribed and taken correctly, I can produce the effective relief for which I am intended.

Amid all this controversy, I ask you to reflect on and re-examine my merits. Think back on the patients in your practice who have been helped through your clinical counseling and prudent prescriptions for me. Consider your patients with heart problems, G.I. problems, and interpersonal problems who, when their anxiety was severe, have been able to benefit from the medication choice you've made. Recall how often you've heard, as a result, "Doctor, I don't know what I would have done without your help."

You and I can feel proud of what we've done together to reduce excessive anxiety and thus help patients to cope more successfully.

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Before prescribing, please consult complete product information, a summary of which follows:

Indications: Management of anxiety disorders, or short-term relief of symptoms of anxiety; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology; spasticity caused by upper motor neuron disorders; athetosis; stiff-man syndrome; convulsive disorders (not for sole therapy). The effectiveness of Valium (diazepam/Roche) in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms similar to those with barbiturates and alcohol have been observed with abrupt discontinuation, usually limited to extended use and excessive doses. Infrequently, milder withdrawal symptoms have been reported following abrupt discontinuation of benzodiazepines after continuous use, generally at higher therapeutic levels, for at least several months. After extended therapy, gradually taper dosage. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other anti-depressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

Dosage: Individualize for maximum beneficial effect. **Adults:** Anxiety disorders, symptoms of anxiety, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. **Geriatric or debilitated patients:** 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) **Children:** 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

Supplied: Valium® (diazepam/Roche) Tablets, 2 mg, 5 mg and 10 mg—bottles of 100 and 500; Tel-E-Dose® packages of 100, available in trays of 4 reverse-numbered boxes of 25, and in boxes containing 10 strips of 10; Prescription Paks of 50, available in trays of 10.

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March 1981 Morbidity Report

Disease	Mor. 1981 Total	1981 to Date	1980 to Date	Most Mor. Cases Reported From These Counties
Amebiosis	2	2	0	Boone, Dollos
Brucellosis	0	0	0	
Chickenpox	1424	4115	4158	Scattered
Cytomegalovirus	4	6	0	Jefferson, Morion Wopello
Eaton's Agent infection	0	8	3	
Encephalitis, virol	3	4	6	Henry, Jones, Lee
Erythema infectiosum	123	350	74	Poweshiek, Block Hawk, Cedor
Gastroenteritis (GIV)	2427	9030	9843	Polk, Linn, Clinton, Johnson
Giordiosis	1	10	5	Woodbury
Hepatitis, A	43	104	31	Guthrie, Scott
Hepatitis, B	7	20	22	Scattered
type unspecified	6	17	22	Polk
Herpes Simplex	13	44	25	Johnson
Herpes Zoster	0	2	0	
Histoplasmosis	0	3	8	
Infectious mononucleosis	49	123	132	Linn, Polo Alto, Block Hawk
Influenza, lob confirmed	53	178	70	Polk, Jackson
Influenza-like illness (URI)	6756	39478	38847	Polo Alto, Johnson, Shelby
Meningitis oseptic	2	18	7	Jackson, Muscotine
bacterial	10	32	32	Polk
meningococcol	2	9	3	Block Hawk, Scott
Mumps	8	28	13	Scott
Pertussis	1	2	0	Woodbury
Robies in animols	73	193	67	Washington, Woodbury, Chickosow
Rheumatic fever	2	5	0	Clinton, Delowore
Rubello (German meosles)	0	0	3	
Rubeolo (meosles)	0	1	0	
Solmonello	14	46	27	Polk, Story
Shigellosis	1	11	21	Polo Alto
Tuberculosis total ill	4	30	15	Apponoose, Dubuque
bact. pos.	3	18	12	Apponoose, Dubuque
Venereol diseases: Gonorrheo	364	1067	1074	Block Hawk, Polk, Scott
Syphilis	4	8	4	Dubuque

Laboratory Virus Diagnosis Without Specified Clinical Syndrome: Adenovirus — 2, Des Moines, 1, Linn; Guillain Barre Syndrome — 1, Scott; Legionnaire's — 1, Johnson; Mononucleosis — 7, Block Hawk, 2, Davis, 2, Dubuque, 1, Franklin, 15, Linn, 1, Modison, 1, Morsholl, 2, O'Brien, 10, Polo Alto, 5, Polk, 2, Pottowottomie, 1, Worren; Scarlet Fever — 1, Clinton, 1, Delowore, 1, Linn, 4, Polk; Coxsockie — 1, Jackson; Compylobacter — 2, Dubuque; Toxic Shock Syndrome — 1, Scott.

STATE DEPARTMENT/PUBLIC HEALTH

(Continued from page 216)

2. We will see a greatly increased interest in the reimbursement mechanism. We have learned that CON has not had any appreciable effect on the rate of increase in costs. The current thinking (although Clark Havighurst and Alain Enthoven have been saying it for some time now) is that we must give serious thought to the things for which we are paying, the providers to whom we are making payment and the method by which we pay. Many people believe we have made it too easy to utilize the highest levels of care. They argue the reimbursement mechanism must be changed to encourage prevention, education, and the lowest level of care consistent with quality. We may see a vigorous and thoroughgoing re-examination of *every* presupposition currently informing the reimbursement mechanism.

3. We will see increased activity by business and industry groups which have become interested in health care delivery the past 3 to 5 years. With the passing of the health systems agencies these groups will be more involved in policy decisions at the local level. The state health planning and development agencies will probably play a mediating role, balancing the interests of those groups with the interests of the population at large.

4. The state health plan will become more policy oriented as the state agencies assume responsibilities in the administration of the block grants. The states will be required to rank programs as to importance, and the statewide needs and priorities in the state health plan will be a first step in that process. The highest priority in the states now is to get ready to administer the block grants when they are given to the states next October.

I believe these are reasonably accurate predictions of trends and activities over the next few years. However, immediate problems must be confronted. If Congress makes funding decisions affecting health planning without at the same time changing the law, confusion could result. The health systems agencies will continue to exist for, in many cases, up to a year and a half. Local decisions will have to be made concerning their activities in this time. Provider associations also have some decisions

to make in the short term. Even though the health systems agencies seem to have only a short time to operate, the expectations they have generated in the consumer sector will continue to live. The public will continue to demand a commitment from doctors and hospitals to cost-effective local planning. The pressure will be there for those associations to come forward with their plans to carry out that commitment.

The return of authority to the states, and the lifting of federal regulations over this industry, and others, issues a challenge to the states and to the providers. These decisions, if fully implemented, herald radical changes. The health of the people depends upon how effectively we anticipate and plan for those changes.



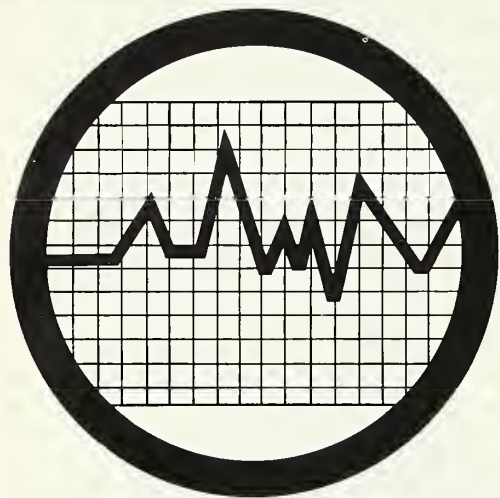
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ABOUT IOWA PHYSICIANS

Dr. Robert Carney, Grinnell, was guest speaker at recent meeting of the Gilman Club. Dr. Carney spoke on death and the dying patient. . . . **Dr. Lane A. Reeves** is taking a leave of absence from his ob-gyn practice in Waterloo to accept a fellowship in reproductive endocrinology and infertility at the Johns Hopkins University Hospital. Dr. Reeves will return to Waterloo in July, 1982. . . . **Dr. George D. Everett**, associate professor in the U. of I. Department of Internal Medicine, was one of 5 physicians selected by the American College of Physicians to receive a 3-year teaching and research scholarship. Starting in July, Dr. Everett will work on 4 projects at the U. of I. College of Medicine — 2 on the delivery of health care services, and 2 on the incidence of disease in a rural aged population. . . . **Dr. W. D. Haufe**, Bloomfield, recently retired from his medical practice because of ill health. Dr. Haufe had practiced internal medicine at the Gilfillan Clinic for 31 years. . . . **Dr. Galen Van Wyhe** will join Rock Rapids physicians, **Drs. Richard Honderick** and **Steven Ferguson** following completion of his family practice residency. A former Rock Rapids resident, Dr. Van Wyhe received the M.D. degree of U. of I. College of Medicine and is serving his family practice residency at University Hospitals.

. . . **Dr. Richard M. Caplan**, associate dean, Continuing Medical Education, U. of I. College of Medicine, has been appointed to a 3-year term on the 18-member Accreditation Council for Continuing Medical Education. Dr. Caplan will represent the Association of Medical Colleges. . . . **Dr. Saheb Sahu**, Des Moines, was a visiting professor in the Department of Pediatrics at V.S.S. Medical College in

Burla, India, in January. . . . **Dr. George Hegstrom**, Ames, was guest speaker at a recent meeting of the Hardin County Medical Society. Dr. Hegstrom spoke on diabetes. . . . **Dr. Michael P. Corder**, associate professor of internal medicine, U. of I. College of Medicine, has been awarded the A. Blaine Brower Traveling Scholarship. Dr. Corder will study Medical Decisions Analysis — Operations Research. . . . A continuing medical education program of the McFarland Clinic, Ames, has involved recent presentations by the following clinic staff — **Drs. Cameron Stokka, Leo Milleman, G. Suarez, Jack Dodd, Loren Olson, Mark Broderson** and **Allen Lang**.

Dr. Laine Dvorak will join Park Physicians in Humboldt in August. Dr. Dvorak received the M.D. degree at U. of I. College of Medicine and completed his family practice residency in Waterloo. . . . **Dr. George Wexler** recently opened a urology practice in Charles City and New Hampton. Dr. Wexler has joined the medical staff at Floyd Memorial Hospital in

(Please turn to page 222)



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Charles City and Saint Joseph Community Hospital in New Hampton. A native of Canada, he received his medical training at the University of Montreal and the Royal College of Medicine in Montreal. For the past 2 years, Dr. Wexler has been on the medical staff of the Valley View Medical Center in Cedar City, Utah. He plans to make his home in Charles City. . . . **Dr. Charles Sokol**, State Center physician since 1946, has retired from active practice. Dr. Sokol received the M.D. degree at U. of I. College of Medicine and located in State Center following military service in World War II. He and Mrs. Sokol plan to remain in State Center. . . . **Dr. Kenneth Gee**, Shenandoah, recently was elected to a 7-year term on the Shenandoah Memorial Hospital board of directors. A Shenandoah physician for 32 years, Dr. Gee is vice president of the Shenandoah Music Association; past member of the Shenandoah Community School District Board of Education; past president of the Chamber of Commerce and past president of the Shen II Creative Artists Association. . . . **Dr. Albert L. Clemens**, Des Moines, has earned a recent recertification from the American Board of Surgery.

Dr. John Ebensberger and **Dr. Paul Royer** will begin family practice in Charles City this summer. Dr. Ebensberger received the M.D. degree at U. of I. College of Medicine and completed his family practice residency in Davenport. Dr. Royer received the M.D. degree at U. of I. College of Medicine and completed his family practice residency in Des Moines. . . . **Dr. Robert Gitchell**, Ames, was a recent visiting consultant for the orthopedic residents at U. of I. College of Medicine Resident's Day. . . . **Dr. James German**, Des Moines, is the first Iowa physician to be certified in emergency practice by the American Board of Emergency Medicine. A former medical director of the Emergency Department at Mercy Hospital Medical Center in Des Moines, Dr. German is currently president of the Physicians Corporation at Mercy.

Dr. Charles Sokol, longtime State Center physician, retired in January. Dr. Sokol received the M.D. degree at U. of I. College of Medicine and interned at Youngstown, Ohio. He began his medical practice in State Center

in 1946. . . . **Dr. John Tapp** has been named chief of staff at Northwest Community Hospital in Des Moines; **Dr. Don Green**, vice chief of staff; and **Dr. Harold Eklund**, secretary/treasurer. All are Des Moines physicians.

DEATHS

Dr. Walter O. Regnier, 80, formerly of Mt. Pleasant, died March 7 in Phoenix, Arizona. Dr. Regnier received the M.D. degree at St. Louis University Medical School in Missouri and completed his residency in psychiatry at City Hospital in St. Louis. Prior to retiring in 1966, Dr. Regnier was on the staff at the Veterans Hospital in Knoxville and Mental Health Institute in Mt. Pleasant.

Dr. Elmer A. Larsen, 77, longtime Centerville physician, died March 20 at his home in Denver, Colorado. Dr. Larsen received the M.D. degree at U. of I. College of Medicine. He began his medical practice at Centerville in 1930, retiring in 1972. After retirement from his medical practice, he moved to Denver, Colorado, where he was employed by the AMA in the National Physicians Service program. Dr. Larsen was a 40-year member of Lions International.

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FAMILY PRACTICE OPPORTUNITIES — in outstanding southern Minnesota group, The Albert Lea Clinic, P.A., is interested in contacting physician candidates for city and small town branch practices. This group is a 16-man multispecialty group in the primary and secondary care fields. Top salary first year. Senior physician participation beginning at the end of the first year, an incentive income distribution plan. LOW cost buy in. Maximum profit sharing plan. Top level insurance plan and full range of other benefits. New hospital in city. Albert Lea is an exceptional place to live and these are choice practices. Please contact B. J. Boss, Administrator, Albert Lea Clinic, P.A., 1602 Fountain St., Albert Lea, Minnesota 56007. Phone 507/373-8251, personal phone 507/377-1406 or contact T. F. Thompson, M.D., 507/373-8251, personal phone 507/373-0259.

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In The Public Interest

Profile of Iowa Medical Practice



THE IOWA MEDICAL SOCIETY took a survey recently. Member physicians were asked to express themselves on more than 60 items of interest. Nearly 40% of the lengthy questionnaires were returned. That's good participation.

With this response level the findings can be said to reflect medical opinion in Iowa with substantial accuracy. The tabulations have been presented to those physicians who served in the 1981 IMS House of Delegates earlier this month. And they have been summarized in this May IMS JOURNAL.

What is there of interest we might comment on here?

Well, apparent stability of practice for one thing. One-third of the physician respondents said they have practiced in Iowa for more than 25 years. Better than half had 16 or more years in Iowa. Here's the breakdown:

LENGTH OF IOWA PRACTICE

0 TO 5 YEARS	25%
6 TO 15 YEARS	24
16 TO 25 YEARS	18
MORE THAN 25 YEARS	33

The number of solo practitioners has diminished over the past decade or more. But it is interesting almost one-third of those who answered gave solo as their type of practice. The highest category (39%) was group specialty.

TYPE OF PRACTICE

GROUP SPECIALTY	39%	GOVERNMENT	2%
SOLO	32	RESIDENT	2
GROUP MULTISPECIALTY	13	HOSPITAL ADMINISTRATION	1
MEDICAL SCHOOL FACULTY	6	OTHER	3
NOT IN PRACTICE	2		

The place of respondents' medical study was about as is known. Nearly half (46%) said their

undergraduate medical study was at the University of Iowa. The percentage reporting postgraduate training at the U. of I. was 25.

The number of hours devoted to medical practice each week was high, as might be expected. More than 60 hours of work was indicated by 43% of those who answered.

APPROXIMATE NUMBER OF HOURS PRACTICED PER WEEK

LESS THAN 40	5%	60 TO 69	26%
40 TO 49	19	70 TO 79	11
50 TO 59	33	MORE THAN 80	6

As for patients seen in a day, the questionnaire appeared to err by not having more entry options at the higher levels. Testimony to this is the 43% who said they see more than 25 patients per day.

APPROXIMATE NUMBER OF PATIENTS SEEN DAILY

1 TO 5	5%	16 TO 20	14%
6 TO 10	8	21 TO 25	17
11 TO 15	8	MORE THAN 25	43

How long do Iowa patients wait to see their doctor for a routine visit? Better than three-quarters of the respondents say such a wait is a week or less in their office. This appears to speak well for the access to medical care.

APPROXIMATE WAIT FOR A ROUTINE VISIT

ONE DAY	34%	TWO TO THREE WEEKS ...	6%
LESS THAN A WEEK	42	ONE MONTH	2
ABOUT TWO WEEKS	12	MORE THAN A MONTH ...	4

The age of Iowa physicians, based on the survey, is balanced well among the three career decades. There is a slight margin (29%) in the 51 to 60 range.

AGE DIVISION OF RESPONDENTS

UNDER 30	4%	51 TO 60	29%
31 TO 40	25	61 TO 70	15
41 TO 50	21	OVER 70	6

Solicited in the survey were Iowa physician opinions on the cost of care, medical manpower, peer review, physician discipline, public expectation, etc. This was the real meat and potatoes section which has been reported elsewhere. The exercise was a good one (a) for those nearly 1,200 physicians who allowed time to give their opinions, and (b) for those who will use the findings to help decide on priorities/strategies for the coming months.

May 1981

Journal of the Iowa Medical Society



QUESTIONS - ANSWERS

STEPHEN ELLIOTT, D.O., Ph.D.
Des Moines, Iowa

HOME AWAY FROM HOME

Dr. Elliott is on the board of Children's Oncology Services of Iowa, Inc., a not-for-profit corporation formed to build and operate the Ronald McDonald House. Dr. Elliott is a pediatric hematologist/oncologist.

The Ronald McDonald House opens in Des Moines this month. What is its purpose?

The Ronald McDonald House is to be a home away from home for parents whose children are hospitalized in any Des Moines-area hospital. Its primary purpose is to help families of children who have leukemia and various other blood diseases and tumors by allowing parents to be near their child while he/she is receiving radiation and chemotherapy. It will provide cheerful, short-term residential housing for parents and families of children while they are being treated.

Where is it located?

The House is located in Des Moines on Pleasant Street near 14th. It is a block away from the Blank Memorial Hospital for Children.

Who sponsors the Ronald McDonald Houses? Where did the idea originate?

The Ronald McDonald House is primarily sponsored by the McDonald Corporation. The idea originated in Philadelphia in 1974.

How many Ronald McDonald Houses are there in the United States and where are they located? How was Des Moines selected?

There are at least 23 such houses in use throughout the United States with approximately 14 more in progress. Des Moines was not selected, a community simply begins a long process of applying for various funds and sponsorship. As a pediatric hematologist/oncologist in Des Moines, I have seen firsthand the hardships of the parents who drive long distances to be with their children while they are receiving chemo and radiation therapy. Often these parents spend weeks and months sleeping on the floor away from normal family circumstances. After I suggested the idea, it was primarily the hard work of Elizabeth and Jim Spoerl that brought the Ronald McDonald House to reality.

What are the eligibility requirements for residents? Is it available only to families of terminally ill patients?

Eligibility for residency varies with each house. In Des Moines the house is to be used primarily for children who have various malignancies while they are being treated in any Des Moines hospital. However, since we do not anticipate this will fill the Ronald McDonald House each night the parents and close relatives and families of any child who is seriously ill and under treatment in a Des Moines hospital will be welcome to use the facilities. There are no eligibility requirements for the residents other than they must be the parents and relatives of a child being treated in a Des Moines hospital.

How many rooms are available? What is the charge?

There are going to be approximately 11 rooms available and the charge (if the parents can pay) will be \$6 per night.

How was the money raised for this project?

The money for the Ronald McDonald House was raised through a variety of projects. The

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Priorities/Responsibilities In Perspective

WILLIAM R. BLISS, M.D.

Ames, Iowa

EACH YEAR the retiring president of the Iowa Medical Society is given an opportunity to speak to those colleagues serving in the House of Delegates. This is a good tradition. I appreciate the chance to continue it. My year as Society president has been active and interesting. I am grateful for the high level of member interest. And I appreciate the hospitality shown

These remarks were presented by Iowa Medical Society President William R. Bliss, M.D. on May 2, 1981 at the Annual Meeting of the House of Delegates. Dr. Bliss concluded his term of office on May 3, 1981.

At a healthy point in its existence, the Iowa Medical Society must provide good professional review if we are to maintain our public credibility. Success in this respect will ward off a return of more federal bureaucracy. These thoughts were shared with the 1981 House of Delegates by retiring President Bliss.

me during visits with various county medical societies and other organizations.

Whether the president of the Iowa Medical Society is speaking to professional colleagues at county or specialty society meetings, as has been my pleasure, or appearing before 500 or so eager Iowa youngsters who are exhibitors at the Hawkeye Science Fair, as has also been my

Continue Unmatched Record

JOHN H. KELLEY, M.D.

Des Moines, Iowa

MR. SPEAKER, OFFICERS, DELEGATES, GUESTS:

Let me begin by expressing my thanks to all of you for the opportunities which lie ahead. I am honored to serve as president of the Iowa Medical Society.

Almost 20 years ago I accepted the job as chairman of the Iowa Medical Society Committee on Legislation. One hardly needs to enumerate the significant events that have impacted on the practice of medicine over these two decades. We have progressed from a

These inaugural remarks were delivered by Dr. Kelley on May 3, 1981 following his installation as president of The Iowa Medical Society.

The new president of the Iowa Medical Society challenges the profession to continue its strong leadership. While suggesting there is always room for improvement, Dr. Kelley cites statistics showing the relatively good comparative cost picture of Iowa alongside nearby states.

shortage of physicians to an ample, some say even a surplus, supply of medical manpower. Starting with Medicare and Medicaid, the government's involvement in medicine has multiplied geometrically. Our relationship to all sorts of paramedical groups has been in a constant state of flux.

A review of the policies of organized medicine during this difficult period reflects a progressive and an even-tempered attitude to-

recent pleasure, the job is an important one. It involves representing you, representing the medical profession within its own ranks and before the public.

Our recent survey of Iowa physician opinions produced findings to show that Society members place a priority interest on having good representation. This means the leadership of the IMS has a responsibility to deliver this representation effectively. And so the president and the other officers who appear in your behalf during the year must state the positions of medicine with clarity. This job of leadership is one of consequence that I have come to respect more in this year of service.

The remarks of a retiring president often take the form of a stewardship report. Or sometimes they constitute candid observations on current issues. My comments are somewhat of a mixture. Suffice it to say they will be brief in the knowledge that the 1981 report of the Board of Trustees serves well as a summary of current programs and activities.

A brief reference to membership is in order. The participation by Iowa physicians in their

professional medical organizations is excellent; it is envied by many other states. Nationally, for example, Iowa has been recognized a fifth consecutive year for increasing its previous annual membership in the American Medical Association.

MEMBERSHIP STRONG

As of April, the active, dues-paying membership in the Iowa Medical Society stood at 2,394 physicians. The total membership was 3,061; this includes all of the membership categories — active, life, associate, resident and student. This is an increase of 66 members over the same date last year.

Because the level of membership has increased, a sound financial position has been achieved and, barring unforeseen circumstances, it should be maintained in 1981-82. Therefore, the Board of Trustees is not asking for an increase in IMS dues.

Over 50% of the physicians who answered the recent IMS survey said the Society should

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wards change. Though we have not been 100% successful in implementing all of our positions, we have scored enough victories to preserve the practice of high quality medicine.

During the next decade, the pace of change is likely to accelerate. However, progress should carry us toward more realistic goals. Massive programs that employ the shotgun approach to solving health problems hopefully will give way to precise solutions to specific problems. This course is more and more dictated by our increasingly limited resources.

Ninety per cent of Americans depend on their personal physician for health care. By the same token they expect that we will take responsibility for seeing to it their care is the best that can be provided. This means we must provide the leading role in health care planning. We cannot relinquish this obligation to social planners, laymen, administrators or bureaucrats.

The medical profession's record of excellence is unmatched by any other profession. American medicine is the best in the world, and in Iowa it is a comparative bargain as well. According to American Hospital Association

statistics, in Iowa per capita hospital expenses were \$278 in 1979. This is 25% less than comparable costs in Illinois; 6% less than Minnesota; 32% less than in Kansas and 6% less than hospital care for the average American. Reimbursement for physicians' services for those over 65 was \$197 per Medicare recipient in Iowa during the year 1979. Kentucky was the only state in the union where this figure was lower. Specialists' fees charged under Medicare were higher in 41 other states than in Iowa. This is not to suggest there is no room for improvement. Hospital utilization in Iowa is higher than we all would like but the bottom line: that is, cost per capita for physician and hospital care finds Iowa ranked far below the average state. Hopefully, private utilization review and new insurance policies with increased emphasis on out-patient care will help slow down accelerating medical care costs.

I think we need to reflect on our extremely successful track record so we can move further into the 80's with the vigor and confidence it takes to be strong leaders in the tumultuous times ahead. Thank you for your interest and your anticipated future participation.



PRESIDENTIAL FLAVOR: New Iowa Medical Society President John H. Kelley, M.D., Des Moines, is shown left with his wife, standing alongside retiring IMS President William R. Bliss, M.D., Ames, and Mrs. Bliss.

assign substantial priority to matters relating to limited licensed practitioners. In this connection, it is heartening that in 1981 a Chicago jury found the AMA and 12 other defendants innocent of charges brought by five chiropractors. It was alleged that medicine had conspired to

"We are fortunate to have a good legislative program in place at the Iowa Medical Society. We may not prevail on every issue but our performance record is extremely good."

monopolize health care services and to unreasonably restrain chiropractors in their efforts to provide services. This case is being appealed but the results to date are gratifying.

We hope the Chicago verdict will have a favorable impact on the Iowa case which is now proceeding through discovery and apparently to trial. As you know, 10 chiropractors have formed the Health Equalization Committee of the Iowa Chiropractic Society to sue the Iowa Medical Society, the AMA and several other organizations and individuals.

ASSISTANCE PROGRAM

Significant progress has been made this year by the Iowa Medical Society in the development of an Assistance Program for Troubled Physicians. I acknowledge the work of Dr. Rassek and his colleagues in this area. The program is well organized and has already served 10 or more physicians. IMS member physicians are urged to be alert to potential problems

among colleagues and to encourage early attention to such problems before they reach the point of jeopardizing a medical career.

The legislative efforts of the Society are progressing favorably in 1981. More activity seems to have been devoted to rules and regulations this year. Here again the matter of representation is important — for the medical profession, through the IMS, is seeking to resolve issues with pharmacy, nursing, physician's assistants, etc., in the interest of quality care delivery. We are fortunate to have a good legislative program in place at the Iowa Medical Society. We may not prevail on every issue but our performance record is extremely good. We have been successful also in the elective or political sense. In 1980, through IMPAC, Iowa medicine saw 80% of the 95 candidates it supported come out victorious. As for representation on the hill, we are fortunate to have an able legislative chairman in Clarence Denser; a respected legislative counsel in Jim West, and good back-up from IMS administrative staff.

Another topic worthy of brief emphasis centers in the malpractice sphere. Physicians are continually urged to communicate — with patients, with colleagues, and allied workers. Most physicians do so conscientiously. But there is always room for improvement. We need to be as positive as possible in our communications. Occasionally, physicians will be unthinkingly critical of their peers. This kind of talk can produce suspicions of poor or in-

(Please turn to page 248)

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THINGS YOU SHOULD KNOW

1981 HOUSE ACTIONS

A mini-report on 1981 IMS House of Delegates' actions is presented as this month's In The Public Interest. 1981 House actions were also highlighted in the May IMS UPDATE. John H. Kelley, M.D., Des Moines, was installed as IMS president May 3 as the House adjourned. His remarks to the delegates and those of retiring President William R. Bliss, M.D., Ames, appear in this issue.

PACKAGING, LABELING

New rules of the Board of Medical Examiners became effective in May covering the packaging, labeling and records of Rx drugs dispensed by a physician. Under the new regs, containers meeting certain requirements must be used. A label is now necessary showing name/address of the physician, patient name, date dispensed, directions and any cautionary statement -- plus name and strength of the Rx drug in the container. Packaged drug samples are exempted from the preceding. Appropriate records must be kept also.

SURGICAL ASSISTING

Assistant at Surgery is the title of a new document of the Iowa Foundation for Medical Care. The volume lists for reference procedures that generally do not require the participation of an assistant. It is for distribution to Iowa hospitals and may be requested by a medical clinic or office. This effort builds on previous considerations of the subject by the IMS Committee on Medical Service.

LEGISLATION WINDUP

As this is prepared, the Iowa General Assembly is winding up its session. Additional 1981 GA attention still needs to be given reapportionment. Appropriations of interest to the IMS appear likely to receive acceptable funding. Defensive legislative efforts of the Society seem to have been successful.

HEALTH CARE COSTS

Immediate Past President W.R. Bliss, M.D., is among 11 Iowans named in May by Governor Ray to a Commission on Health Care Costs. Over the next 24 months the Commission will study the dynamics of Iowa health care costs and pursue recommendations to correct any identified problems.

VETO BY GOVERNOR

Administrative rules allowing RN's to dispense only 48-hour supplies of medications (and LPN's not at all) have been vetoed by Governor Ray. These rules were recommended by the Iowa Board of Nursing. Consideration of other rules has been set back for a time by the Iowa Administrative Rules Review Committee.

CURTAILMENT NOT NEEDED

Earlier cost-containment plans to eliminate optional Medicaid services in June have been cancelled. Included here were dental, optometric, podiatric, chiropractic, etc., services. Provider training sessions are continuing in June under auspices of the Iowa Medicaid fiscal agent, System Development Corporation.

RABIES PROBLEMS

The heavy incidence of rabies in Iowa continues to cause widespread concern. The number of rabies cases reported to the State Department of Health has exceeded 350, more than three times the number in 1980. Central Iowa is reportedly hardest hit.

FOUNDATION DESIGNATION

The name of the Society's educational/research/benevolence arm became Iowa Medical Foundation last month. The name has been Scanlon Medical Foundation/Iowa Medical Society. The new title is believed to better reflect the broadening activities of the Foundation. Separate named entities will exist under the Foundation, e.g., Dr. George Scanlon Medical Student Loan Fund and the Dr. Henry Albert Benevolence and Public Health Fund.



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When using neomycin-containing products to control secondary infection in the chronic dermatoses, it should be borne in mind that the skin is more liable to become sensitized to many substances, including neomycin. The manifestation of sensitization to neomycin is usually a low grade reddening with swelling, dry scaling and itching; it may be manifest simply as a failure to heal. During long-term use of neomycin-containing products, periodic examination for such signs is advisable and the patient should be told to discontinue the product if they are observed. These symptoms regress quickly on withdrawing the medication. Neomycin-containing applications should be avoided for that patient thereafter.

PRECAUTIONS: As with other antibacterial preparations, prolonged use may result in overgrowth of non-susceptible organisms, including fungi. Appropriate measures should be taken if this occurs.

ADVERSE REACTIONS: Neomycin is a not uncommon cutaneous sensitizer. Articles in the current literature indicate an increase in the prevalence of persons allergic to neomycin. Ototoxicity and nephrotoxicity have been reported (see Warning section). Complete literature available on request from Professional Services Dept. PML.



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VOX DOCS

Please take a look at this month's Vox Docs question. It's below! Give us your opinion. Send it to IMS JOURNAL, 1001 Grand Avenue, West Des Moines, Iowa 50265. Last month's question and answer results are shown to the right with several of the comments we received printed below.

"The traditionally high public acceptance of medicine has diminished some. Factors of bad publicity and absence of full professional unity are partial reasons." — A. G. Chanco, M.D., *Mason City*

"Rising costs, malpractice issues, governmental activity, emerging paramedical personnel have 'chipped away' at the doctor image. We have to shoulder some of the blame but most of any attitude change has been caused by factors over which we have no control." — R. T. Guthrie, M.D., *Waterloo*

"We suffer from poor PR. We are targets for mass media and the legal profession and other health professionals. A good PR program is needed." — R. J. Barry, M.D., *Cedar Rapids*

LAST MONTH'S QUESTION —

Has the high public acceptance of medicine slipped and in need of concerted attention?

NEEDS STEPPED-UP ATTENTION	73%
PUBLIC ATTITUDE BASICALLY UNCHANGED	27%
NO OPINION	0

"Primary care physicians seem to enjoy the loyalty and respect of their patients. Subspecialists probably have a higher percentage of patients who view them less favorably. On the whole, physician personality is the overwhelming factor on the individual basis. The profession still has an awesome, respected image." — J. H. Gay, M.D., *Des Moines*

"Patients are better informed and want to participate more in decisions regarding their care. Our daily attitude of concern and commitment is the best way to improve our image." — D. B. MacMillan, M.D., *Waverly*

JUNE QUESTION FOR IOWA PHYSICIANS

Steps to spur the availability of generic drugs have been initiated by the federal administration. Such action is generally opposed by the brand-name manufacturers. How do you feel on the subject — balancing the need to assure and control quality in medications against competitive pricing?

- ☐ EASE REQUIREMENTS FOR GENERIC MANUFACTURERS
☐ RETAIN PATENT/OTHER REQUIREMENTS FOR OPTIMUM PUBLIC PROTECTION
☐ NO OPINION

Comment, Please _____

Name _____

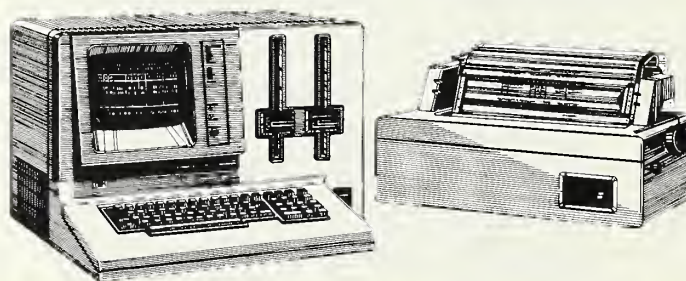
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Pulmonary Paragonimiasis: A Case Report

BRIAN J. HEINEMAN, D.O., and
LORAN F. PARKER, M.D.
Des Moines, Iowa

The presence of persons recently arrived from Southeast Asia brings new matters for attention by Iowa physicians. Here is the case of pulmonary paragonimiasis uncovered in a Laotian male and treated successfully.

PULMONARY PARASITIC INFECTION, or pulmonary paragonimiasis, is a form of hemoptysis commonly seen in many Third World countries today. It is a chronic disease of the lung caused by trematodes of the genus *Paragonimus*. There are 30 separate species of these lung flukes, but the type *westermani* most usually infects man. *Paragonimus westermani* is widely distributed in the Far East and is endemic in Laos, Viet Nam, Philippines, Thailand, Korea, Japan and Central China.

This report describes a case of pulmonary paragonimiasis in an adolescent and illustrates a cause of persistent hemoptysis that is unusual in this country but should nevertheless be considered by physicians who treat immigrants from Southeast Asia.

Dr. Heineman is a 1980 graduate of the Broadlawns Family Practice Residency Training Program, Des Moines, Iowa, and is currently in family practice in Story City, Iowa. Dr. Parker is Director of Family Practice Training at Broadlawns Medical Center, Des Moines, Iowa, and Associate Professor, Department of Family Practice, College of Medicine, University of Iowa.

CASE REPORT

An 18-year-old Laotian male presented at Broadlawns Family Health Center in March, 1980, complaining of having coughed up blood for approximately one year. The patient immigrated to this country 4 months prior to his initial clinical evaluation at Broadlawns. He reported having been in good health and denied exposure to tuberculosis. He was taking no medication and had had a normal chest x-ray before coming to this country.

The review of systems was unremarkable except for purulent blood-tinged sputum produced each morning upon arising. The patient was a healthy, afebrile male weighing 53 Kg. Auscultation of the chest revealed harsh airway sounds without rales or ronchi. No skin lesions were noted. There was no organomegaly and stool examination was negative for occult blood. The white blood cell count was 10,800, the hemoglobin 17.3 gm%, hematocrit

THE SCANLON MEDICAL FOUNDATION/IOWA MEDICAL SOCIETY HAS DESIGNATED THIS ARTICLE
AS THE HENRY ALBERT SCIENTIFIC PRESENTATION FOR THE MONTH OF JUNE 1981

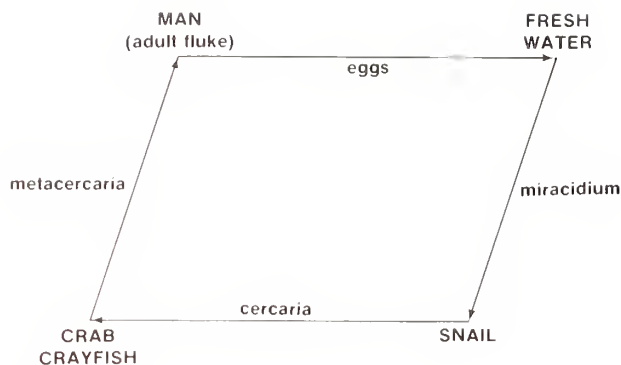


Figure 1. Schematic life cycle of *Paragonimus westermani*.

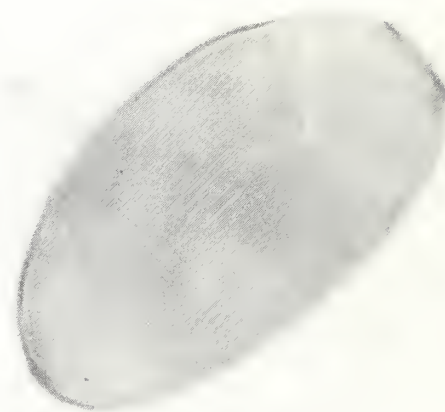


Figure 2. *Paragonimus westermani* egg.

47 vol% and the differential cell count was 52 polys, 1 band, 25 lymphocytes, and 22 eosinophils. Routine chemistries were normal except for an SGOT of 88 (normal 8-42). An initial chest x-ray showed 2 cavitory lesions, one in the right middle lobe and a second, smaller lesion in the left anterior superior lobe (See Figure 3). Tomography of the larger lesion indicated a 4 cm cavity. A 250 IU strength PPD was negative 3 days after administration. Six acid-fast stains of sputum produced without stimulation contained no organisms, and cultures showed no growth after 6 weeks. Wright's stain of the sputum revealed 45% eosinophils. A potassium hydroxide preparation of the sputum gave no evidence of fungal disease and fungal cultures were negative; however, ova approximately 85 μ in size were found which were characteristic of *P. westermani*. Several stools for ova and parasites contained only hookworm and *Giardia*.

PATHOGENESIS

P. westermani is a short, plump adult fluke with a life span of 4 to 5 years, usually spent in the lung parenchyma of the host. Its golden-brown eggs reach the bronchioles where they are either coughed out in thick sputum or swallowed. The eggs embryonate for several weeks in fresh water and hatch to produce miracidia which invade snails of certain species. The snails are consumed by fresh water crabs, and the cercariae then encyst in the crabs' muscles

and viscera. Man acquires the infection by eating the crabs raw or partially cooked.

Larval flukes released from the metacercaria usually migrate to the lung via the peritoneal cavity, penetrating the diaphragm, but may mature in the abdomen, brain, or skin. The larval fluke tunnels in to the lung where it forms a granuloma which eventually develops into a fibrous cyst. The fluke generally matures in 6 weeks and begins producing eggs which are discharged into the sputum following rupture of the cyst. The cycle is then repeated.

CLINICAL MANIFESTATIONS

The clinical features of pulmonary paragonimiasis resemble chronic bronchitis and bronchiectasis. A poorly resolving pulmonary infiltrate, a lung abscess, and/or a pleural effusion may be present in heavy infections. Roentgenographic examinations vary with the stage of the infection. Initially, one or more soft infiltrates may be seen anywhere in the lung except the apices. These infiltrates are gradually replaced by round nodules which frequently cavitate. Eventually fibrosis and calcification occur, closely resembling tuberculosis. (Tuberculosis coexists with paragonimiasis in 2% of cases.)

Diagnosis of paragonimiasis depends primarily on finding ova in the sputum and/or stool with the use of potassium hydroxide preparation. Eggs may be rare or totally absent from the sputum during the first 3 months of

infection, but they are eventually found in 75-85% of infected cases. Unfortunately, methods of sputum concentration and staining common to routine investigation of tuberculosis usually destroy any eggs that may be present. Complement fixation titers may be useful, but the extent to which the *Paragonimus* antigen cross-reacts with other species of flukes has not been clearly shown.

TREATMENT AND PREVENTION

Bithionol (Lorothidol), the treatment of choice, is given orally in the dose of 30-50 mg/Kg on alternating days for 10-15 doses. Minor side effects have been reported — usually a rash, diarrhea, and/or abdominal cramping. Following initiation of this medication, symptoms disappear rapidly and the host infiltrates usually resolve within 3 months.

Because of limited demand, bithionol has not been licensed in this country for internal use, and must therefore be restricted by federal law to clinical investigation. The Parasitic Disease Drug Service of the National Center for Disease Control has obtained permission from the FDA to supply licensed physicians with oral bithionol in certain situations.*

In southeast Asia the most practical control measure is the adequate cooking of all shellfish before eating. However, some oriental customs of eating uncooked shellfish are not easily relinquished. For example, "Drunken Crab," a favorite dish, involves immersing live crabs in alcohol prior to consumption. Likewise, fresh crab juice is used as a Korean home remedy in the treatment of measles. In the United States effective sewage systems have thus far eliminated the need for control measures.

PATIENT RESPONSE TO THERAPY

This patient responded promptly to the prescribed one-month course of therapy. With only 5 doses of bithionol therapy, complete eradication of eggs from the sputum was noted, along with near remission of hemoptysis symptoms. After 5 weeks of treatment, chest x-ray examination showed a 50% resolution of cavity size (see Figure 4). At 3 months the cavity was totally obliterated (See Figure 5).

(Please turn to page 248)

* Physicians who request consultation in dealing with parasitic diseases should call Parasitic Disease Drug Service, Bureau of Epidemiology, CDC, Atlanta, Georgia, 404-329-3676.

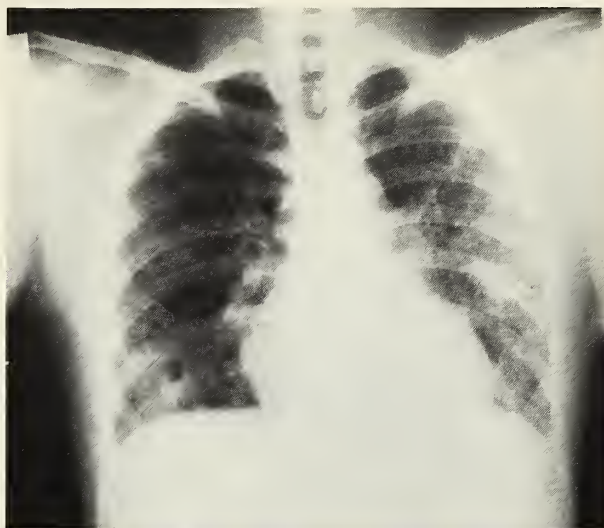


Figure 3. Pre-treatment chest x-ray showing cavitary lesions in the right middle lobe and in the left anterior superior lobe.



Figure 4. Chest x-ray 5 weeks after beginning of bithionol treatment. Resolution of cavity size is about 50%.

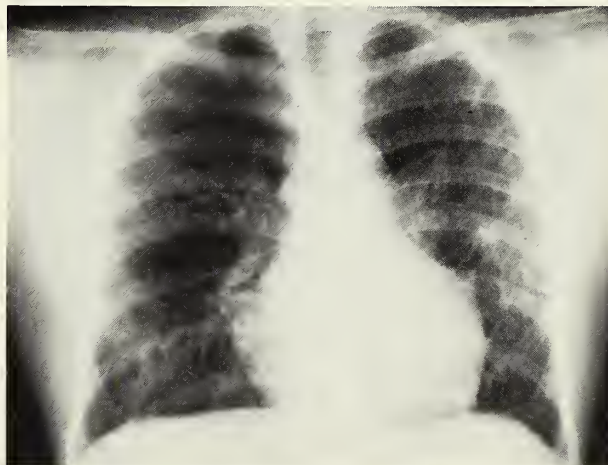


Figure 5. Chest x-ray 3 months after beginning of treatment reveals cavitary obliteration.

PULMONARY PARAGONIMIASIS: A CASE REPORT

(Continued from page 247)

The only side effect noted during the course of therapy was urticaria and a macular rash which occurred approximately 14 days into therapy and lasted until the therapy was completed. The rash was treated with Benadryl 25 mg twice a day for 2 weeks, until the final dose of bithionol was taken. Post-therapy blood examination revealed no change from the pre-therapy evaluation.

PRIORITIES/RESPONSIBILITIES IN PERSPECTIVE

(Continued from page 238)

appropriate care in the minds of some patients. Inadvertent and inappropriate remarks may lead to groundless, time-consuming legal action.

We need always to demonstrate patience and tolerance for those who work with us in the health care field. We need to build a climate where fairness and understanding are priority goals. When we do so we strike a real blow at the "damage suit" environment which has emerged.

PROFESSIONAL REVIEW

In saying these things I mean in no way to downgrade the value and benefit of qualified and constructive professional review programs. We have a responsibility to monitor all aspects of medical care delivered in Iowa.

This leads me to another topic. At its interim session last December, the AMA House of Delegates voted to support repeal of the Professional Standards Review Organization Program. The position of the Reagan Administration also favors abandoning PSRO. In its history PSRO has exerted federal pressures more to deal with cost restraint than with quality of care. The performance in both areas has been unremarkable based on the investment of tax dollars.

In its action related to PSRO, the AMA House of Delegates noted additionally that the

SUMMARY

Although pulmonary paragonimiasis is rarely the cause of hemoptysis in this country, it should be considered when pulmonary disease is found in people who have recently immigrated from Southeast Asia. Clinical manifestations resemble tuberculosis, and concomitant disease does exist. Accurate diagnosis is essential, however, since bithionol is the approved treatment for paragonimiasis.

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A brief bibliography on paragonimiasis is available from the authors or from the JOURNAL OF THE IOWA MEDICAL SOCIETY.

medical profession has a responsibility to see the public is provided quality care. In recent remarks to a Senate Finance Subcommittee, Dr. Joe Boyle, vice-chairman of the AMA Board of Trustees, said, "In the absence of government direction and interference the profession will vigorously review and strengthen private sector peer review activities."

To this end we must do at least two things:

First, we must provide good, objective quality medical review if we are to maintain our credibility with the public in general and with various special segments of the public, such as business and industry.

Secondly, by providing this professional medical review service in the private sector we will ward off a return of federal regulatory and bureaucratic impositions. This seems to me to be a goal worthy of serious pursuit.

In closing I would like to express appreciation to Eldon Huston, Tina Preftakes, Don Neumann, Tim Gibson, Dean Gillaspey, Wendell Stone and the rest of the Iowa Medical Society administrative staff for excellent cooperation and support. They have made this job a pleasant experience.

I am confident that Iowa physicians, and particularly those who are the conscientious members of the Iowa Medical Society, are well-trained and dedicated to the care of their patients. I salute each of them and each of you for the services you are providing. I have been proud to represent you as president of the Iowa Medical Society.

Lyme Arthritis in the Midwest: A Diagnostic Challenge

R. F. DRYER, M.D.,
J. A. BUCKWALTER, M.D.,
A. S. CARNEY, M.D., and
S. L. WEINSTEIN, M.D.
Iowa City, Iowa

Described here is recently identified disease which has appeared in the Midwest. Three cases of Lyme arthritis are noted as having been diagnosed at the University of Iowa. The association with a tick bite is significant.

LYME ARTHRITIS is a recently identified disease which has appeared in the Midwest. Initially, all reported patients with Lyme arthritis lived in New England and the syndrome was thought to be limited to this area. Recently, however, we have identified the syndrome in 3 patients from Wisconsin.¹ Although we are not aware of any definite examples of Lyme arthritis in Iowa, the diagnosis should be considered in patients who develop systemic illness, a rash, and arthritis, especially with the history of a previous tick bite.

Since the diagnosis of Lyme arthritis depends entirely on clinical findings, physicians must be familiar with the presentation of this disease. Its cause remains unknown although it probably is infectious and viral transmission by tick bite is strongly suspected. The disease is characterized by: 1) a distinctive skin rash, erythema chronicum migrans; 2) systemic

manifestations including fever; 3) nondeforming monarticular or oligoarticular arthritis; and 4) geographic clustering of patients suffering from the illness. The disease also may be associated with elevated serum IgM levels, elevated erythrocyte sedimentation rate, neurologic abnormalities and myocardial conduction abnormalities.²

Erythema Chronicum Migrans: Erythema Chronicum Migrans is the most consistent and characteristic manifestation of Lyme arthritis. It begins as a small firm red spot on the skin that spreads in a centrifugally expanding ring. The expanding erythema often has an indurated advancing edge and may gradually spread to form a ring as large as 50 centimeters in diameter.³ Often the lesion will clear centrally except for the original center which will remain as a bright erythematous spot. This center is often the site of the previous tick bite. The skin lesion is usually not painful or pruritic and may last anywhere from a few days to 8 weeks and then fade spontaneously.

Systemic Manifestations: Systemic symptoms often develop prior to the first attack of arthritis and usually during the presence of the rash. Malaise, fatigue, chills and fever, myalgia,

The authors are associated with the Department of Orthopaedics at the University of Iowa Hospitals and Clinics.

headache and stiff neck are the most common symptoms associated with the onset of the skin lesion and may precede it by several days. Frequently, an initial diagnosis of meningitis or encephalitis is made. Generalized lymphadenopathy, splenomegaly, periorbital edema, facial nerve palsy and myocardial conduction abnormalities have also been described.^{2, 4} Cultures of blood, cerebrospinal fluid, and throat are almost always unremarkable. The spontaneous resolution of the systemic manifestations usually occurs within three to seven days.^{1, 2, 4}

Arthritis: Joint manifestations are characterized by unpredictable remissions and exacerbations. The arthritis usually begins suddenly, involves one or a few large joints asymmetrically and may be migratory. The knee is most commonly involved followed by the shoulder, elbow, and temporomandibular joints. Rarely, the small joints of the fingers and toes may be involved. The onset of the initial attack of the arthritis varies from one to 22 weeks from the onset of the skin lesion with the median being about 4 weeks. Duration of the arthritic attacks ranges from one day to as much as 3 months. The average duration, however, is 7 to 10 days. The patient invariably has a spontaneous resolution of the arthritis and develops a complete remission only to have another arthritic episode. The period of remission is highly variable ranging from 1 to 7 weeks.^{1, 2, 4} Our experience suggests that each succeeding arthritic episode is milder than the preceding one. Physical examination of involved joints usually finds a hot tender joint with a painful reduced range of motion. The overlying skin is not typically erythematous but a joint effusion is invariably present. Certainly gonococcal, septic and juvenile rheumatoid arthritis needs to be excluded in such a patient.

HISTORY

Lyme arthritis has been occurring in the eastern Connecticut area since at least 1972, and is named for the community where it was first identified, Lyme, Connecticut.⁴ Only when tight geographic clustering of cases appeared in mid-1976 was the syndrome identified. The peak incidence occurs in the summer and early fall corresponding with the height of the tick population, and clusters of

affected patients usually are found near an area of tick infestation. The disease occurs with equal frequency among males and females and affects people of all ages.

The 3 patients we have seen demonstrated the characteristic features of this disease as illustrated by the following patient history:

CASE ILLUSTRATION

A 23-year-old white man presented in June 1977 after noticing a lump on the back of his neck. He had been camping in northwestern Wisconsin with a group of 10 other people constructing a cabin. On the day of presentation, many ticks were removed from his hair and skin. The following day he developed severe headache, stiff neck, generalized myalgia, anorexia, fatigue, and malaise. Two days later he appeared severely ill, a tentative diagnosis of meningitis was made and the patient was transferred to a medical center for evaluation. Physical findings include a temperature of 40°C (104°F), sinus tachycardia, meningismus, and an erythematous plaque on his right medial proximal thigh. The skin lesion, measured 30 cm in diameter, was raised, tender, and displayed central clearing. Active synovitis was not detectable but the shoulders, elbows, and knees were tender.

The following laboratory studies were normal: complete blood count and differential, blood cultures, mono-spot test, serum viral titers, tests for antinuclear antibodies and rheumatoid factor, serum protein electrophoresis, cultures for gonococci, and cerebrospinal fluid examination, including routine cultures.

The initial diagnosis was cellulitis and the patient was treated with cephalothin. During the next 3 weeks, the rash, fever, arthralgia, and malaise resolved. Approximately 2 months later he developed acute arthritis with warmth, erythema, and swelling, predominantly of the shoulders and knees. This episode lasted 3-4 days and subsided completely. Over the next 3 months he had 3 similar episodes of arthritis, each lasting 7 to 10 days, and each responding to salicylate therapy. Between episodes he was entirely asymptomatic and took no medication.

Conclusion: Our 3 patients developed the characteristic clinical features of Lyme arthritis:

(Please turn to page 252)

...takes dietary restriction, regular exercise, behavior modification, and sometimes the addition of an effective anorectic.

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Brief Summary

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WARNINGS: If tolerance develops, the recommended dose should not be exceeded in an attempt to increase the effect; rather, the drug should be discontinued. Tenuate may impair the ability of the patient to engage in potentially hazardous activities such as operating machinery or driving a motor vehicle; the patient should therefore be cautioned accordingly. **Drug Dependence:** Tenuate has some chemical and pharmacologic similarities to the amphetamines and other related stimulant drugs that have been extensively abused. There have been reports of subjects becoming psychologically dependent on diethylpropion. The possibility of abuse should be kept in mind when evaluating the desirability of including a drug as part of a weight reduction program. Abuse of amphetamines and related drugs may be associated with varying degrees of psychologic dependence and social dysfunction which, in the case of certain drugs, may be severe. There are reports of patients who have increased the dosage to many times that recommended. Abrupt cessation following prolonged high dosage administration results in extreme fatigue and mental depression; changes are also noted on the sleep EEG. Manifestations of chronic intoxication with anorectic drugs include severe dermatoses, marked insomnia, irritability, hyperactivity, and personality changes. The most severe manifestation of chronic intoxications is psychosis, often clinically indistinguishable from schizophrenia. **Use in Pregnancy:** Although rat and human reproductive studies have not indicated adverse effects, the use of Tenuate by women who are pregnant or may become pregnant requires that the potential benefits be weighed against the potential risks. **Use in Children:** Tenuate is not recommended for use in children under 12 years of age.

PRECAUTIONS: Caution is to be exercised in prescribing Tenuate for patients with hypertension or with symptomatic cardiovascular disease, including arrhythmias. Tenuate should not be administered to patients with severe hypertension. Insulin requirements in diabetes mellitus may be altered in association with the use of Tenuate and the concomitant dietary regimen. Tenuate may decrease the hypotensive effect of guanethidine. The least amount feasible should be prescribed or dispensed at one time in order to minimize the possibility of overdosage. Reports suggest that Tenuate may increase convulsions in some epileptics. Therefore, epileptics receiving Tenuate should be carefully monitored. Titration of dose or discontinuance of Tenuate may be necessary.

ADVERSE REACTIONS: **Cardiovascular:** Palpitation, tachycardia, elevation of blood pressure, precordial pain, arrhythmia. Dne published report described T-wave changes in the ECG of a healthy young male after ingestion of diethylpropion hydrochloride. **Central Nervous System:** Overstimulation, nervousness, restlessness, dizziness, jitteriness, insomnia, anxiety, euphoria, depression, dysphoria, tremor, dyskinesia, mydriasis, drowsiness, malaise, headache, rarely psychotic episodes at recommended doses. In a few epileptics an increase in convulsive episodes has been reported. **Gastrointestinal:** Dryness of the mouth, unpleasant taste, nausea, vomiting, abdominal discomfort, diarrhea, constipation, other gastrointestinal disturbances. **Allergic:** Urticaria, rash, ecchymosis, erythema. **Endocrine:** Impotence, changes in libido, gynecomastia, menstrual upset. **Hematopoietic System:** Bone marrow depression, agranulocytosis, leukopenia. **Miscellaneous:** A variety of miscellaneous adverse reactions has been reported by physicians. These include complaints such as dyspnea, hair loss, muscle pain, dysuria, increased sweating, and polyuria.

DOSE AND ADMINISTRATION: Tenuate (diethylpropion hydrochloride): Dne 25 mg. tablet three times daily, one hour before meals, and in mid-evening if desired to overcome night hunger. Tenuate Dospan (diethylpropion hydrochloride) controlled-release: Dne 75 mg. tablet daily, swallowed whole, in mid-morning. Tenuate is not recommended for use in children under 12 years of age.

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LYME ARTHRITIS IN THE MIDWEST: A DIAGNOSTIC CHALLENGE

(Continued from page 249)

1) A large erythematous skin lesion typical of erythema chronicum migrans; 2) fever; 3) meningismus; 4) myalgia; and 5) transient, migratory oligoarthritis predominantly involving knees, shoulders, and elbows. Following the initial illness, each has suffered recurrent episodes of oligoarthritis separated by periods of complete remission. One year after the onset of arthritis none of the patients had persistent synovitis or joint deformities.

Several points warrant emphasis. First, Lyme arthritis occurs outside of coastal New England and may well exist in the Midwest. Second, our patient histories confirm the association between the syndrome of Lyme arthritis and antecedent tick bites. Third, each of our patients demonstrated severe systemic illness

at onset which was initially diagnosed as meningitis or meningoencephalitis. Arthritis was absent in the early stages and became prominent only after resolution of systemic symptoms. The key to early diagnosis is the characteristic skin lesion. Fourth, the early systemic manifestations usually are self-limiting and recurrent episodes tend to become more mild with time. Fifth, specific appropriate therapy for Lyme arthritis is not known, but until its pathogenesis is better understood only symptomatic treatment seems feasible except for the rare patients with neurologic or myocardial conduction abnormalities.

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Arthroscopic Meniscectomy

PETER D. WIRTZ, M.D.

Des Moines, Iowa

THIS IS A brief report on 51 continuous cases of operative arthroscopic meniscectomy in a private practice setting between April 1979 and October 1980. The short term results have been gratifying. The anticipation is the procedure will continue to be effective to surpass long term formal arthrotomy results.

The techniques of diagnostic and operative arthroscopy of the knee have been described by many authors.¹⁻⁴ This is an analysis of only those requiring partial meniscectomy.

In this series 50 patients required 51 operative arthroscopies. One male patient required reoperation on a retained fragment in the peripheral area of an initial bucket handle excision. Forty-six were men and four were women. Meniscectomies included 34 medial, 13 lateral and 4 bilateral partial excisions. There were 31 right and 20 left knee operations. The age range was from 16 to 81, with 66% younger than 40.

The onset of symptoms prior to surgery varied from a recent injury to as long as 8 years. The longer the symptoms were present and the older the patient, the closer the association of articular cartilage damage. Arthrography was not used in this series to aid in diagnosis.

The surgical technique of arthroscopic surgery requires general or regional anesthesia because the instruments are usually 3 to 6 mm in diameter. Video visualization is used during surgery and recording of pertinent parts of the

Arthroscopy of the knee has helped in diagnostic accuracy and also decreased postoperative morbidity. This short report highlights aspects of 51 procedures over an 18-month period. The results present an encouraging picture.

procedure is done for documentation. The average operating time was 70 minutes.

Postoperatively, the patients were encouraged to ambulate as soon as possible. Some are done entirely as outpatient procedures, whereas most are discharged the day after surgery (92%). 8% required 2 to 3 days postoperative management before discharge because of associated arthritis or low pain thresholds. Non-narcotic oral analgesics were used occasionally. There have been no cases of postoperative infection, stiffness or thrombophlebitis. A postoperative exercise program was required in 20% to strengthen their quadriceps musculature. Ambulation upon discharge is unassisted.

CONCLUSION

Operative arthroscopic meniscectomy allows the patient an accurate diagnosis and surgical correction with little morbidity. The patients are able to go home soon after surgery and rehabilitate themselves quickly; many returning to light work in 2-3 days and heavy labor 3-4 weeks after surgery. The amount of arthritis in the knee determines the length of rehabilitation and the final result.

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The author is in the private practice of orthopedic surgery in Des Moines, Iowa.

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COMMENTING EDITORIALY

MARION E. ALBERTS, M.D.
SCIENTIFIC EDITOR

ERADICATE THOSE WEEDS

AN UNDESIRABLE WEED has invaded the lawn of my home. The experts say it is not crabgrass. They say further the only effective way to eliminate it is by extensive removal of the roots. Another alternative is to use an all-purpose herbicide which would eliminate the grass at the same time. So, to preserve the lawn many hours will need to be spent on hands and knees alternately (a) praying for successful eradication, (b) digging and pulling, and (c) cursing the diabolic invader. It seems at times that unwanted growth thrives more successfully than the bluegrass, especially in view of our present scarcity of rain.

Life is comparable in a way to lawn maintenance. Undesirable weeds sometimes invade the good aspects of living. Our personal and professional endeavors are often a delicate balance between fighting the weeds and giving in to the undesirable. I believe this country is taking a hard look at itself; there appears to be a changing of our sense of values and goals. There seems to be more concern for integrity and self-sufficiency, though many still fight these trends. Some would argue that our social structure is out of kilter and the attitude of the people is selfish and larcenous. Crime abounds in many areas. Yet, more and more people are showing a positive concern for social responsibility; there seems to be a renewal and strengthening of moral attitudes. Government officials are developing new attitudes about expensive programs of questionable worth.

Some diehards are still trying to save their favorite projects, but the voices in favor of less government spending are more prominent.

There is no question that Americans on the whole live better than people in other parts of the world. True, there are those at the top, and those much less fortunate, but the mean is much broader here than in any other place. Many government programs provide more for the administrators than for the intended recipients. Much overlapping wastes time and money, and let us not forget that government programs are paid by taxpayer money.

Let us look briefly at an example of overlapping. Under Title XIX infants and children are entitled to medical care and advice about proper nutrition from their personal physician or clinic. They may also go to another governmental program for advice about nutrition and then receive supplemental foods as a bonus. It would seem arrangements could be made for physicians and clinics to have the

"Life is comparable in a way to lawn maintenance. Undesirable weeds sometimes invade the good aspects of living. Our personal and professional endeavors are often a delicate balance between fighting the weeds and giving in to the undesirable."

necessary instructional materials and requisitions for the supplemental foods . . . all to be taken care of at one visit. This is an extra expenditure of government monies, the patients' time, and the cost of transportation. At one stop, the medical care, the nutritional guidance, and the supplemental foods could be given.

This is a superficial analysis of the situation, but the governmental "weeds" have invasive roots and eradication is difficult. Our people must be given the opportunity to seek help when needed, yet maintain their dignity in that endeavor. Coordination of effort can create economy of operation. Life can be nurtured through unselfish, thoughtful mechanisms and the weeds of governmental waste in effort and money can be eliminated. As professional persons, we can help in our capacity as health advisors and as responsible citizens, to promote good and worthwhile governmental programs. — M.E.A.

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OUR MAN ON EDUCATION

RICHARD M. CAPLAN, M.D.

AUDIT CRITERIA = STANDARDS?

My perceptions tell me that Iowa physicians have come a long way in their understanding of the process of medical care evaluation since I first learned about it in 1971 and held workshops around the state in 1972. Back then, a great number (maybe a majority) of the doctors seemed to think that any effort by physicians, alone or in groups, to look systematically and critically at their own medical work was either unprofessional, immoral or idiotic, and surely inspired by Satan, "the Feds," the Kremlin or all of the above. And not only that, but such efforts would produce excess litigation, a return of the level of medical care to that of the Dark Ages, a jail sentence, fiscal ruin or all of the above.

Happily, it can be reported now that the abundance of Cassandras has dwindled to a ridiculous-sounding few. The usual concern now is more a mechanical one — the effort is laborious, expensive and yields too little precious metal for the ore that must be processed. There is a much greater openness to self-examination with its potential for self-criticism and self-improvement.

Yet not all is serene philosophically. There remain occasional physicians who seem unwilling to accept any degree of peer review,

clinging instead to a curious notion of total and inviolable personal autonomy with no obligation for accountability of any kind. They seem to believe they *do* have the right to yell "fire" in a crowded theater. A larger group is not as extreme, but remains suspicious that structured efforts to examine physicians' work must inevitably produce more mischief than good. That seems born, I think, of the continuing failure to understand that an "element" or "criterion" in a medical care evaluation study is not a standard conceived to dictate performance in every instance under scrutiny. Rather, it is an indication of a generally reasonable and acceptable behavior which allows for exceptions. If an element has a "100%" beside it, we must understand it for what it is, simply a way of instructing the medical records personnel which records need to have a judgment made by the physicians involved in the peer review process. No physician was ever held in error in the eye of his fellows or the law just because of non-performance of an element in an audit; no

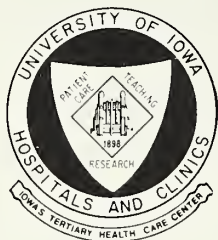
"There remain occasional physicians who seem unwilling to accept any degree of peer review, clinging instead to a curious notion of total and inviolable personal autonomy with no obligation for accountability of any kind."

mechanical or non-professional review can by itself now lead to a presumption of error or suboptimal practice. The clear answer to the question of the title is "No."

Although audit technology has slowly grown more sophisticated, accurate and fruitful, it still has a long way to go. It is not a panacea for anything whatever, but only a tool to help identify problems or inadequacies of care so that improvement might occur. The crucial judgments about what good care means remain where they should — with the profession, as do the decisions about whether any individual variation represents an appropriate clinical judgment rather than lapse. We have an alternative system called litigation, using non-peer and peer testimony to decide in retrospect whether a particular behavior was appropriate. As an overall system for improving care and providing continuing education, medical audit is far better.

Dr. Caplan is Associate Dean for Continuing Medical Education at The University of Iowa College of Medicine.

DRUG THERAPY REVIEW



UNIVERSITY OF IOWA HOSPITALS AND CLINICS

REYNOLD SPECTOR, M.D., Editor

TREATMENT OF ATYPICAL PNEUMONIA

WITH THE INTRODUCTION of sulfonamides and penicillin into medical practice, physicians rapidly discovered a small but significant group of pneumonias which were unresponsive to these antibiotics and which were clinically and radiographically different from typical pneumococcal pneumonia. These "atypical pneumonias" accounted for about 20% of pneumonias in the general population and were initially felt to be caused by viruses. Over the years, the atypical pneumonias have been revealed as an etiologically diverse group composed of mycoplasmal, chlamydial, rickettsial, fungal, and bacterial agents as well as viruses.

Although the number of potential pathogens in atypical pneumonia is great, serologic studies in Iowa indicate that *Mycoplasma pneumoniae*, *Legionella pneumophila*, and influenza A virus infections account for the great majority of cases for which an etiology can be found.¹ Since *mycoplasmal* and *legionellal* pneumonias are prevalent and treatable, this

article will emphasize antibiotic therapy for these infections.

MYCOPLASMAL PNEUMONIA

M. pneumoniae, formerly the Eaton agent, is the premier etiologic agent of cold-agglutinin positive primary atypical pneumonia. In children over the age of 5 years and the young adults to the age of 40 years, *M. pneumoniae* is the most common cause of pneumonia. Rarely fatal, mycoplasmal pneumonia is often a protracted and disabling illness associated with significant morbidity.²

M. pneumoniae organisms lack a cell wall and are therefore uniformly resistant to penicillin and cephalosporin antibiotics which inhibit cell wall synthesis. Clindamycin also appears ineffective in human infection.³

The efficacy of erythromycin and tetracycline antibiotics in mycoplasmal pneumonia is well established, however. Erythromycin, and tetracycline and its congeners inhibit mycoplasmal growth *in vitro* at concentrations attainable *in vivo* and are equally therapeutic in animal models of *M. pneumoniae* disease.⁴⁻⁶ A carefully conducted randomized, double-blind, controlled clinical trial in military recruits with mycoplasmal pneumonia documented the efficacy of demethylchlortetracycline in shortening the duration of fever (from 10 to 3 days), cough (from 21 to 9 days), rales and x-ray abnormalities (from 20 to 9 days).² These results are supported by less rigidly controlled studies with other tetracyclines.^{3, 5, 7-9} Trials comparing the tetracyclines with erythromycin have shown the latter to be equally effective.^{5, 8, 9}

Tetracycline failure in mycoplasmal pneumonia is not well documented. Two cases of pneumonia which did not respond after one week of oxytetracycline therapy (1 gm/day) subsequently responded to erythromycin (1 gm/day).¹⁰ A relapse rate of 13% has been reported following tetracycline therapy, but the dose and duration of therapy in this study were not specified.⁹

Based on available data, erythromycin or tetracycline (1-2 gm/day po in four divided doses) for 10-14 days is recommended for treatment of mycoplasmal pneumonia. Unfortunately tetracyclines are contraindicated in many individuals in whom mycoplasmal pneumonia is prevalent: in children less than 9 years of age

This information for Iowa physicians is furnished and sponsored by the University of Iowa Hospitals and Clinics.

and in pregnant women. In addition, tetracycline therapy should be avoided in women of childbearing age unless pregnancy can be excluded.

LEGIONELLAL PNEUMONIA

Pneumonia caused by *Legionella pneumophila* (Legionnaires' disease) is an acute disease, affecting adults over the age of 40 years primarily. Individuals receiving corticosteroids, immunosuppressive or antineoplastic therapy appear prone to infection. Illness may vary from mild and self-limited to fulminant, progressive, and fatal. The incidence of legionellal pneumonia is greatest in the late summer and early autumn months.

Knowledge of antibiotic efficacy in legionellal pneumonia is still in its infancy. It is known that *L. pneumophila* produces a β -lactamase enzyme, which probably accounts for its uniform resistance to penicillin and cephalosporin antibiotics *in vitro* and *in vivo*. Erythromycin and rifampin, on the other hand, are effective *in vitro* and in experimental infections of embryonated eggs and guinea pigs. Tetracyclines appear less efficacious.

Efficacy of erythromycin in human disease is inferred from retrospective analysis of antibiotic therapy in outbreaks of Legionnaires' disease.¹² Case-fatality ratios have been about 13% in patients treated with erythromycin and about 55% in untreated patients or those treated with other antibiotics.¹² Relapses following erythromycin therapy have been reported for cases treated for less than three weeks.¹² Rifampin has been employed, with success, in cases failing to respond to erythromycin.¹¹ Clinical responses have been reported with tetracycline and trimethoprim — sulfamethox-

azole as well, but less consistently and less frequently than with erythromycin.¹²

Available clinical and laboratory data indicate that erythromycin is the drug of choice for *L. pneumophila* pneumonia. Doses of 2-4 gm/day in 4 divided doses for at least three weeks are recommended. Intravenous delivery is recommended initially for the seriously ill patient. The addition of rifampin (600 mg bid) should be considered in patients responding poorly to erythromycin alone.

CONCLUSIONS AND GENERAL RECOMMENDATIONS

In Iowa the most commonly identified causes of atypical pneumonia are *M. pneumoniae*, *L. pneumophila*, and influenza A virus. Because of clinically overlapping findings, the differentiation of these pneumonias is often difficult. Laboratory findings are often equally nonspecific. Cases of mycoplasmal, legionellal, and influenzal pneumonias, unlike most cases of pneumococcal pneumonia, present with a nondiagnostic sputum gram strain. Unfortunately, sputa from pneumococcal pneumonias are not always "classic" with numerous pus cells and Gram-positive diplococci. The patient presenting to the primary physician with a fever, pulmonary infiltrate, and nondescript sputum gram stain, therefore, poses a diagnostic and therapeutic dilemma. Since, with the exception of the viral pneumonias which do not respond to antibiotics, all the aforementioned pneumonias are treatable with erythromycin, there is a rationale for the institution of erythromycin therapy in this clinical situation. It should be stressed that while an empiric approach to treatment is often necessitated by the clinical presentation, it is no

(Please turn to page 260)

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DRUG THERAPY REVIEW

(Continued from page 259)

substitute for pursuing a definitive diagnosis when practical.

If the patient is previously healthy and ambulatory, oral erythromycin 250-500 mg qid for adults and 8-15 mg/kg qid for children is recommended. This should be continued for 10-14 days (for mycoplasmal pneumonia) or 3 weeks (for legionellar pneumonia). Side effects of oral erythromycin include epigastric distress and must be distinguished from the symptoms of the illness being treated. Rare allergic reactions and hepatotoxicity have been observed. If the adult patient is seriously ill, erythromycin 0.5-1 gm intravenously every 6 hours (children 15 mg/kg IV q 6h) is recommended until defervescence occurs, and then oral therapy is given to complete the course. Intravenous erythromycin is locally irritating and may cause phlebitis. — *Randall W. Lengeling, M.D., Fellow, Division of General Internal Medicine, and Charles M. Helms, M.D., Ph.D., Assistant Professor, Division of Infectious Diseases, Department of Internal Medicine, U. of I. College of Medicine.*

QUESTIONS/ANSWERS

(Continued from page 235)

McDonald Corporation, owners of the Des Moines and central Iowa McDonald's restaurants, has been more than generous. This has been our primary source of money. However, without the support of the Variety Club, the final building of the House would not have been possible. In addition, many groups, organizations and individuals have contributed separately and collectively to make the Ronald McDonald House a reality. The Iowa Health Care Association had a very successful rummage sale and a variety of people have had various marathons, bowl-a-thons, etc., to raise money.

Are contributions still needed?

Contributions are certainly still needed as we need to complete the decoration and acquire furniture and then pay for the continuous upkeep.

STATE DEPARTMENT/ PUBLIC HEALTH

FURTHER REFUGEE AID

THE IOWA STATE DEPARTMENT of Health has been funded by the Center for Disease Control to develop and implement a refugee health program. The intent of the grant is to assist the state in meeting the public health needs of the incoming refugee.

Indochinese refugees continue to enter the State of Iowa through private and public resettlement agencies at a rate of approximately 100 per month. Screening to identify 4 health problems (tuberculosis, leprosy, venereal disease and mental defects) will have taken place in Southeast Asia as the refugees wait for settlement in the United States. Patients with active disease are treated until noninfectious; they may still be on medication on arrival at their final destination. Many refugees enter the state with previously undetected health problems that will require a medical examination and treatment upon arrival in Iowa. Some of these problems may have public health significance now or in the near future.

It is the recommendation of the Iowa State Department of Health and the Iowa Refugee Service Center that all newly arriving refugees entering the state receive a complete medical assessment. A past medical history will be difficult to obtain because of cultural differences

and communication problems. A complete physical examination is needed because the evaluation overseas was only a screening procedure.

HEALTH ASSESSMENT FORM

An Iowa health assessment form has been developed by the State Refugee Health Program. The form will be used to notify a designated health agency in each county that a refugee(s) is or has entered the county, and that each should be seen by a local health care provider for a complete medical assessment. The Iowa health assessment form is intended to collect data that will help the physician evaluate the patient. We are requesting local health agencies to provide the State Health Department with notation that each refugee has been seen by a private physician for a medical and dental assessment; this is done by completing the health assessment form and returning a copy to the program.

It is the recommendation of the Center for Disease Control that a complete general evaluation by the private physician should include:

- A. Oral inspection for dental problems for all ages
- B. Vision and hearing
- C. Age, height and weight to assess pediatric nutritional status
- D. Complete blood count
- E. Other laboratory tests as indicated

Tuberculosis is the most serious potential public health problem of Indochinese refugees. At the present, refugees two years and older are screened with a chest x-ray in camps

(Please turn to page 263)

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An added complication... in the treatment of bacterial bronchitis*



Brief Summary
Consult the package literature for prescribing information.

Indications and Usage: Cefclor® (cefclor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms:

Lower respiratory infections, including pneumonia caused by *Streptococcus pneumoniae* (*Diplococcus pneumoniae*), *Haemophilus influenzae*, and *S. pyogenes* (group A beta-hemolytic streptococci).

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Cefclor.

Contraindication: Cefclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS, AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS TO BOTH DRUG CLASSES (INCLUDING ANAPHYLAXIS AFTER PARENTERAL USE).

Antibiotics, including Cefclor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs.

Precautions: If an allergic reaction to cefclor occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e.g., pressor amines, antihistamines, or corticosteroids.

Prolonged use of cefclor may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs test may be due to the drug.

Cefclor should be administered with caution in the presence of markedly impaired renal function. Under such a condition, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended.

As a result of administration of Cefclor, a false-positive reaction for glucose in the urine may occur. This has been observed with Benedict's and Fehling's solutions and also with Clinistest® tablets but not with Tes-Tape® (Glucose Enzymatic Test Strip, USP, Lilly).

Usage in Pregnancy: Although no teratogenic or antifertility effects were seen in reproduction studies in mice and rats receiving up to 12 times the maximum human dose or in ferrets given three times the maximum human dose, the safety of this drug for use in human pregnancy has not been established. The benefits of the drug in pregnant women should be weighed against a possible risk to the fetus.

Usage in Infancy: Safety of this product for use in infants less than one month of age has not been established.

Some ampicillin-resistant strains of *Haemophilus influenzae*—a recognized complication of bacterial bronchitis*—are sensitive to treatment with Cefclor.¹⁻⁵

In clinical trials, patients with bacterial bronchitis due to susceptible strains of *Streptococcus pneumoniae*, *H. influenzae*, *S. pyogenes* (group A beta-hemolytic streptococci), or multiple organisms achieved a satisfactory clinical response with Cefclor.⁷

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Adverse Reactions: Adverse effects considered related to cefclor therapy are uncommon and are listed below. Gastrointestinal symptoms occur in about 2-5 percent of patients and include diarrhea (1 in 70) and nausea and vomiting (1 in 90).

Hypersensitivity reactions have been reported in about 1-5 percent of patients and include morbilliform eruptions (1 in 100). Pruritus, urticaria, and positive Coombs tests each occur in less than 1 in 200 patients. Cases of serum-sickness-like reactions, including the above skin manifestations, fever, and arthralgia/arthritis, have been reported. Anaphylaxis has also been reported.

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients).

Causal Relationship Uncertain—Transitory abnormalities in clinical laboratory test results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician.

Hepatic—Slight elevations in SGOT, SGPT, or alkaline phosphatase values (1 in 40).

Hematopoietic—Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40).

Renal—Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200).

*Many authorities attribute acute infectious exacerbation of chronic bronchitis to either *S. pneumoniae* or *H. influenzae*.⁶

Note: Cefclor® (cefclor) is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

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Additional information available to the profession on request from Eli Lilly and Company, Indianapolis, Indiana 46285. Eli Lilly Industries, Inc., Carolina, Puerto Rico 00630

STATE DEPARTMENT/PUBLIC HEALTH

(Continued from page 261)

in Southeast Asia. Active cases remain in Asia under treatment until the disease is no longer infective. It is required by the immigration law that known classes of tuberculosis make contact with the local health agency within one week after arrival at final destination.

This summary of priority health assessment evaluations for Indochinese refugees is provided by the Center for Disease Control:

1. Tuberculosis according to identified class
2. Childhood immunization per published recommendations
3. Hepatitis B (HBsAg) with the highest priority in

pregnant women and other women of child bearing age

4. Intestinal parasites if the refugee has gastrointestinal symptoms or anemia.

5. Sexually transmitted diseases for symptomatic individuals and those that need additional medication upon entering the state

6. Malaria and bacterial enteric pathogens are not recommended as a routine evaluation.

The refugee health program will be able to provide telephone interpretation in Laotian and Vietnamese throughout Iowa. Educational and other medical bilingual materials are being developed by the program. If assistance and other medical information is needed please call 1-800-532-1420, a toll free number for Indochinese Interpreter Assistance.

April 1981 Morbidity Report

Disease	Apr. 1981 Total	1981 to Date	1980 to Date	Most Apr. Cases Reported From These Counties
Amebiasis	0	2	3	
Brucellosis	0	0	1	
Chickenpox	1175	5290	5277	Scattered
Cytomegalovirus	2	8	4	Jefferson, Marion
Eaton's Agent infection	2	10	7	Corroll, Johnson
Encephalitis, viral	0	4	6	
Erythema infectiosum	255	605	173	Cedar, Bueno Visto, Clinton
Gastroenteritis (GIV)	1498	10528	11300	Scattered
Giardiasis	1	11	6	Webster
Hepatitis, A	16	120	44	Scott, Pottawottomie
Hepatitis, B	4	24	26	Polk
type unspecified	6	23	24	Scattered
Herpes Simplex	20	64	30	Johnson
Herpes Zoster	1	3	0	Davis
Histoplasmosis	2	5	9	Johnson, Scott
Infectious mononucleosis	34	157	160	Black Hawk, Scott, Linn
Influenza, lab confirmed	10	188	96	Scattered
Influenza-like illness (URI)	4365	43843	43095	Scattered
Meningitis septic	1	19	8	Johnson

Disease	Apr. 1981 Total	1981 to Date	1980 to Date	Most Apr. Cases Reported From These Counties
bacterial	16	48	38	Polk
meningococcal	3	12	5	Coss, Dubuque, Scott
Mumps	6	34	24	Scattered
Pertussis	0	2	0	
Robies in animals	102	295	100	Washington, Kossuth, Story
Rheumatic fever	1	6	0	Lee
Rubella (German measles)	0	0	3	
Rubeola (measles)	0	1	15	
Salmonella	16	62	33	Scattered
Shigellosis	3	14	21	Linn, Johnson
Tuberculosis total ill	7	36	26	Polk, Scott
bact. pos.	5	22	21	Polk, Scott
Venereal diseases: Gonorrhea	393	1460	1401	Polk, Scott, Linn, Black Hawk
Syphilis	0	8	7	

Laboratory Virus Diagnosis Without Specified Clinical Syndrome: Adenovirus — 1, Dubuque, 1, Scott; Giardiasis — 1, Webster; Guilloin-Borre — 1, Von Buren; Histoplasmosis — 1, Johnson, 1, Scott; Reye's Syndrome — 1, Woodbury; Scarlet Fever — 1, Clinton, 1, Dollos, 1, Jones, 3, Page, 1, Polk, 3, Shelby, 3, Winnishiek; Blastomycosis — 1, Polk; Typhoid Fever — 1, Linn; Toxic Shock Syndrome — 1, Cerro Gordo, 1, Polk, 1, Scott; Compylobacter — 2, Dubuque, 3, Johnson, 4, Polk, 1, Woodbury.

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The Iowa Foundation for Medical Care (IFMC), with input from the Iowa Medical Society and Blue Cross and Blue Shield of Iowa have developed a list of procedures that can be safely performed in an outpatient setting.

We encourage physicians to familiarize themselves and their patients with the IFMC's list and seek outpatient arrangements whenever appropriate.



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ABOUT IOWA PHYSICIANS

Dr. Roger B. Anderson and **Dr. Joseph E. Prior**, Davenport, each with almost 40 years in medical practice, retired in March. Dr. and Mrs. Anderson plan to move to West Sun City, Arizona, for their retirement years. Dr. and Mrs. Prior will remain in Davenport. . . . **Dr. John Graether**, Marshalltown, recently participated in a seminar in Kansas City. He presented the results of a recent series of 1,000 consecutive lens implantations after cataract extractions. He also discussed and demonstrated with surgical films the specific instruments and techniques developed at the Wolfe Clinic for the implantation of the artificial lens. Dr. Graether recently was named to the National Scientific Advisory Board of Cilco Corporation. This panel of ophthalmic surgeons assists the company in developing new products in the lens implant area. . . . **Dr. Robert E. Donlin**, Harlan, recently was presented the James E. Kelsey Award for his outstanding service to alcoholics and the field of alcoholism and chemical dependency. Dr. Donlin was the first medical director of the Powell III Alcoholism and Treatment Unit in Des Moines. He has been a member of the IMS Committee on Alcoholism and Drug Abuse since 1973 and continues to serve on that committee. . . . At the Class 1-A Basketball championship game, 5 Iowa physicians were recognized for time devoted to their local school athletic programs. Team Doctor Awards were presented to **Milton E. Barrent**, Clinton; **Vincent H. Carstensen**, Waverly; **C. E. Douglas**, Belle Plaine; **Robert E. Jongewaard**, Wesley, and **John M. Rhodes**, Pocahontas.

Dr. John Ellis, Muscatine, was guest speaker at a recent meeting of the Muscatine Rotary Club. Dr. Ellis spoke on "Refugee Relief Work in Thailand." He recently spent 3 months in

Thailand, under the Iowa SHARES Program, treating Cambodians in Thailand refugee camps. . . . **Dr. Stuart Schlanger** began medical practice in Dunlap in March. Dr. Schlanger received the M.D. degree at the University of Washington Medical School in St. Louis, Missouri, and completed his residency in family practice at Creighton University and St. Joseph's Hospital in Omaha, Nebraska. . . . **Dr. Maynard C. Jones, Jr.**, Boone, was guest speaker at a recent meeting of the Boone Kiwanis Daybreakers Club. Dr. Jones presented information on ultrasound and its use at the Boone County Hospital. . . . **Dr. Linda Bickerstaff**, Decorah surgeon, has accepted a 12-month fellowship at the Mayo Clinic in Rochester, Minnesota. Dr. Bickerstaff will study peripheral vascular surgery. **Dr. L. E. Weber, Jr.**, has closed his practice in Burlington to join the Department of Family Practice at the U. of I. College of Medicine. Dr. Weber practiced in Burlington for over 25 years. He

(Please turn to page 266)

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will assume his new position in July. . . . Dr. Mark Odell will join the Muscatine Health Center in August. Dr. Odell received the M.D. degree at the U. of I. College of Medicine and completed his family practice residency at the Grand Rapids Area Medical Education Center in Grand Rapids, Michigan.

DEATHS

Dr. John L. Kestel, 81, Waterloo, died April 22 at his home. Dr. Kestel received the M.D. degree at Creighton University School of Medicine. He began the private practice of radiology in Waterloo in 1929. Dr. Kestel was a diplomate of the National Board of Medical Examiners; fellow of the American College of Radiology; past president of the Iowa Radiological Society; past president of the Black Hawk County Medical Society and life member of the Iowa Medical Society.

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Policies Set By 1981 Delegates



LAST MONTH the Iowa Medical Society House of Delegates met in Des Moines. Such a meeting each spring brings together 150 or so Iowa physicians — chosen by their colleagues back home — for the purpose of deciding how and where the medical profession will direct its energies in the ensuing year. It is an exercise in representative democracy.

The May 1981 session of the House was action-oriented. The agenda was full. And the topics discussed, debated and acted on covered a broad subject range. Policies were either set or reaffirmed in a variety of areas of interest to the public and the profession.

What subjects were covered? Well, most importantly, perhaps, the delegates reaffirmed the need for professionally directed efforts to see that patients get high quality care for the right duration and cost. To show the gamut of subject matter, they supported state requirements that milk be pasteurized.

Business comes before the House mainly as resolutions from county medical societies. The diversity of 1981 subjects is reflected in this listing of House actions:

- *Health Maintenance Organizations* — Advocate fair market competition and neutrality in HMO considerations and discourage preferential federal stimulus. Furnish IMS info/expertise to entities interested in alternate delivery systems.

- *Medicaid* — Seek economic fairness in the reimbursement of services provided to Title XIX patients.

- *Rabies Immune Globulin and Human Rabies Vaccine* — Explore broader access to these supplies through placement in additional Iowa hospitals.

- *Sports Physicals* — Study the idea of requiring school athletic physicals less frequently than the current annual stipulation.

- *Safety Helmets* — Back state legislation to restore mandated helmet wearing by operators of motorcycles or other motorized two-wheel vehicles.

- *Cost of Care* — Emphasize quality of care and cost containment as goals for every physician with unnecessary tests to be avoided.

- *PSRO* — Support replacement of the Professional Standards Review Program with a non-governmental approach to assure the presence of good care.

- *Nursing Home Care* — Pursue the evaluation of physician care of nursing home patients through the Iowa Foundation for Medical Care.

- *Independent Providers* — Advocate that independent nurse practitioners be guided by same Iowa laws as physician's assistants, with ongoing monitoring of proposed regulatory changes in nursing practices.

- *Physician's Assistants* — Discourage expansion of PA training with a further request of the University of Iowa that it consider abandoning the PA training program.

- *Well Elderly Clinics* — Press for activity to assure these facilities are operated efficiently and in accord with established standards.

- *Smoking in Restaurants* — Promote voluntary efforts to encourage public eating establishments to have separate areas for non-smokers and smokers.

- *Drivers Under the Influence* — Support legislation to increase the severity of penalties for those convicted of OMVUI.

- *Physician Dispensing* — Remain opposed to any restriction on dispensing or delegation of non-judgmental tasks by physicians choosing to furnish medications in this manner.

- *Newborn Screening* — Back concept of voluntary appropriated screening programs for detection of newborn genetic and metabolic disorders.

From gavel up to gavel down, it was a busy time. There was good delegate representation of the physician constituency.

June 1981

Journal of the Iowa Medical Society

Summary of the 1981 IMS House of Delegates

Actions of the 1981 Iowa Medical Society House of Delegates are highlighted on the following pages. Dues were retained at their present level. Subjects covered relate to ancillary personnel, health care utilization and cost, peer review, etc.

THE 1981 ANNUAL MEETING of the Iowa Medical Society House of Delegates was May 2 and 3 in Des Moines. Sessions of the House were chaired each day by Lynn D. Caraway, M.D., and William C. Rosenfeld, M.D., speaker and vice speaker, respectively. Open hearings were conducted by three reference committees on May 2. The Delegates' Banquet occurred May 2 and was chaired by President William R. Bliss, M.D. Special remarks were presented by Governor Robert Ray and Alan Nelson, M.D., Salt Lake City, Utah, member, Board of Trustees, American Medical Association.

The 1981 Iowa Medical Society Merit Award recipients were announced as L. W. Swanson, M.D., Mason City; and Ralph L. Wicks, M.D., Okoboji. The 1981 Washington Freeman Peck Award was presented to the National Kidney Foundation of Iowa. The John F. Sanford Award was presented to Governor Robert D. Ray.

MAY 2 SESSION

Registered for the May 2 session of the House were 138 delegates and 11 ex officio members. Minutes of the May 4, 1980 session

of the House of Delegates were approved as summarized in the July 1980 issue of the JOURNAL OF THE IOWA MEDICAL SOCIETY. Reports contained in the 1981 HANDBOOK FOR THE HOUSE OF DELEGATES were approved as published with the following exceptions: (1) the report of the Committee on Medical Practice in Health Facilities and Homes, and (2) the report of the Committee on Delivery of Health Services.

The following reports were made to the 1981 House of Delegates:

Board of Trustees, by Hormoz Rassekh, M.D., chairman. (An audio-visual presentation on the 1981 survey of IMS members accompanied this report.)

Blue Shield, by E. E. Linder, M.D., chairman, Board of Directors.

Iowa Foundation for Medical Care, by John Hess, Jr., M.D., IFMC president.

Iowa Medical Foundation, by Hormoz Rassekh, M.D., president, Board of Directors.

Necrology, by Donald F. Rodawig, Jr., M.D., secretary, Judicial Council.

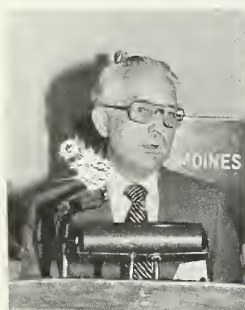
Nominating Committee, by Lawrence O. Goodman, M.D., chairman.

Legislative Committee, by Clarence H. Denser, Jr., M.D., chairman.

Iowa Medical Political Action Committee (IMPAC), by Jackson D. Ver Steeg, M.D., chairman.

A check for \$15,068.56 was presented by Hormoz Rassekh, M.D., chairman, IMS Board of Trustees, to the University of Iowa College of Medicine. The grant represents contributions to the AMA/ERF which have been desig-

(Please turn to page 281)



SUMMARY OF 1981 HOUSE OF DELEGATES

nated for the U. of I. John W. Eckstein, M.D., dean, U. of I. College of Medicine, accepted the check.

Roger Jepsen, U.S. Senator from Iowa, addressed the House briefly. Senator Jepsen reported on this country's change of direction under the Reagan administration.

Supplemental reports from the Standing Committee on Articles of Incorporation and Bylaws; the Committee on Aging and Chronic Illness; the Committee on Alternate Delivery Systems; and the Committee on Assistance Program for Troubled Physicians were contained in the delegates' packets but were not read.

Society President William R. Bliss commented on his year in office. These remarks were published in the June, 1981, issue of the JOURNAL OF THE IOWA MEDICAL SOCIETY.

Twenty-three resolutions were formally introduced and referred to reference committees. Action taken on these resolutions is reported subsequently in this summary.

The following physicians were elected to Life Membership in the Iowa Medical Society:

Black Hawk: Eugene Smith, M.D., Waterloo

Clay: Frank D. Edington, M.D., Spencer
Clayton: Charles N. Hyatt, M.D., Elkader
Dallas-Guthrie: Keith M. Chapler, M.D., and
C. Robert Osborn, M.D., both from Dexter
Davis: Earl E. Gilfillan, M.D., Bloomfield
Fayette: John P. Gallagher, M.D., Oelwein
Grundy: Joseph E. Rose, M.D., Grundy Center
Harrison: Francis X. Tamisiea, M.D., Missouri Valley
Johnson: Alson E. Braley, M.D., Pauline Moore, M.D., and Adolph Sahs, M.D., all of Iowa City
Linn: Robert M. Chapman, M.D., Fremont
Polk: Byron M. Merkel, M.D., Des Moines
Scott: Thomas W. McMeans, M.D., Davenport
Webster: Donald Borgen, M.D., Gowrie, Charlie Coughlan, M.D. and Dan Egbert, M.D., both of Fort Dodge
Woodbury: Frank D. McCarthy, M.D., Sioux City

The following physicians were elected to Associate Membership in the Iowa Medical Society:

Black Hawk: Cecil Siebert, M.D., Waterloo
Cerro Gordo: Egmont Barg, M.D., and Alvin Stue-land, M.D., both of Mason City
Clay: Clare Jones, M.D., Spencer, and John Buchanan, M.D., Milford
Clinton: James J. Young, M.D., Clinton
Dallas-Guthrie: Llewelyn Long, M.D., Perry
Davis: W. D. Haufe, M.D., Bloomfield
Delaware: Holger Anderson, M.D., Naples, Florida
Jasper: Peder Madsen, M.D., Newton

PICTURE HIGHLIGHTS 1981 HOUSE OF DELEGATES

These scenes are from the May 2-3 IMS House of Delegates held in Des Moines: (1) John Kelley, M.D., Des Moines, right, accepts IMS presidential medallion from William Bliss, M.D., Ames. (2) 1981 IMS Merit Award Winner L. W. Swanson, M.D., Mason City, and Mrs. Swanson. (3) Mrs. Harry Dvorsky, San Leandro, California, left, president-elect, AMA Auxiliary; Alan Nelson, M.D., Salt Lake City, Utah, AMA trustee, and Mrs. Nelson. (4) 11 of 19 new IMS Life Members were present. (5) Nominating Committee Chairman L. O. Goodman, M.D., Marshalltown. (6) Newly-elected AMA alternate delegate, Donald C. Young, M.D., Des Moines, left, and re-elected AMA delegate John R. Anderson, M.D., Boone. (7) Hormoz Rassekh, M.D., Council Bluffs, retiring IMS board chairman and new president-elect, left, presents AMA-ERF check to U. of I. College of Medicine Dean John Eckstein, M.D. (8) Mrs. Robert Ray accepts surprise monetary gift from the IMS for the Terrace Hill restoration program. (9) New IMS President and Mrs. John H. Kelley, left, pose with retiring Society President William Bliss and Mrs. Bliss. (10) Blue Shield Board Chairman E. E. Linder, M.D., Ogden, reports to the House. (11) Iowa Foundation for Medical Care President John Hess, Jr., M.D., Des Moines, gives an IFMC update. (12) IMS Legislative Chairman C. H. Denser, Jr., Des Moines, reports. (13) Past IMS presidents, from left, L. W. Swanson, M.D., Mason City, R. S. Gerard, M.D., Waterloo, P. M. Seebohm, M.D., Iowa City, and V. L. Schlaser, M.D., Galena, Mo., serve as election tellers. (14) J. D. Ver Steeg, M.D., Des Moines, left, IMPAC chairman, poses with U. S. Senator Roger Jepsen. (15) Immediate Past President P. M. Seebohm, M.D., Iowa City, right, receives a recognition plaque from President Bliss. (16) New IMS board includes seated, from left, M. E. Kraushaar, M.D., Ft. Dodge, chairman, J. H. Kelley, M.D., Des Moines, president, and J. E. Tyrrell, M.D., trustee and secretary/treasurer. Standing, from left, W. R. Bliss, M.D., Ames, past-president, G. L. Baker, M.D., Iowa City, vice-president, Hormoz Rassekh, M.D., Council Bluffs, president-elect, and E. B. Mathiasen, M.D., Council Bluffs, trustee. (17) Reference Committee on Reports of Officers/Articles of Incorporation, seated from left, G. L. Baker, M.D., Iowa City, Robert Barry, M.D., Cedar Rapids, and Gerald McGowan, M.D., Sioux City. Standing, from left, Amado Chanco, M.D., Mason City, and Claude Koons, M.D., Des Moines. (18) Reference Committee on Medical Service/Miscellaneous Business, from left, Dwight Sattler, M.D., Kalona, Dennis Walter, M.D., Des Moines, John Fernandez, M.D., Council Bluffs, and Paul Ferguson, M.D., Lake City (Gerhard Schmunk, M.D., and James White, M.D., Dubuque, were non-pictured members of the committee). (19) Reference Committee on Legislation, seated from left, Bruce Trimble, M.D., Mason City, John Garred, M.D., Whiting, and Thomas Graham, M.D., Iowa Falls. Standing, left, William Franey, M.D., Cedar Rapids, and Lyle Fuller, M.D., Garner.

SUMMARY OF 1981 HOUSE OF DELEGATES

Johnson: Frank S. Larsen, M.D., Pequot Lakes, Minnesota

Linn: Allen Berndt, M.D., Cedar Rapids

Mitchell: Thomas Walker, M.D., Riceville

Page: Frederick Sperry, M.D., Clarinda

Polk: James Anderson, M.D., Alice Collins, M.D.,

Roger Floren, M.D., Donald Lulu, M.D., Leo Pearlman, M.D., Van Robinson, M.D., James Stecher, M.D., George Young, M.D., all of Des Moines, and Floyd Burgeson, M.D., West Des Moines

Scott: Vera French, M.D., Bettendorf and Joseph Prior, M.D., Davenport

Wapello: Paul Ekart, M.D., Dennis Emmanuel, M.D., William Maixner, M.D., and Justus Roberts, M.D., all of Ottumwa

Webster: Paul M. Kersten, M.D., Fort Dodge, and Lyal J. O'Brien, M.D., Milford

Woodbury: Loren Collins, M.D., Frederick Stark, M.D., Omar Stauch, M.D., and John Tracy, M.D., all of Sioux City

Worth: William McAllister, M.D., Manly

The speaker presented information on the reference committee hearings, the balloting procedures and the concluding session of the House.

MAY 3 SESSION

Registered for the May 3 session of the House were 140 delegates and 11 ex officio members. The minutes of the May 2 session of the House were read and approved.

Mrs. Mary Ellen Kimball, immediate past president, Iowa Medical Society Auxiliary, reported on past projects and several new programs developed during her tenure.

The following physicians were announced as having been elected or re-elected to the positions noted:

President-elect	Hormoz Rassekh, M.D., Council Bluffs
Vice President	George L. Baker, M.D., Iowa City
Speaker of the House	Lynn D. Coraway, M.D., Amana
Vice Speaker	William C. Rosenfeld, M.D., Mason City
Trustee (3-year term)	Emmett B. Mothiosen, M.D., Council Bluffs

AMA Delegate
(2-year term)

John R. Anderson, M.D., Boone

AMA Alternate
Delegate
(2-year term)

Liaison Delegates

Councilors

Donald C. Young, M.D., Des Moines

James F. Bishop, M.D., Davenport

J. D. Ver Steeg, M.D., Des Moines

Kenneth D. Dolon, M.D., Iowa City (2)

Robert A. Sautter, M.D.,

Mt. Vernon (3)

Robert T. Melgaard, M.D., Dubuque (4)

Dennis J. Walter, M.D., Des Moines (8)

John W. Olds, M.D., Des Moines (9)

Donald F. Rodawig, Jr., M.D.,

Spirit Lake (13)

Highlights and actions of the Reference Committee reports are summarized as follows:

Reference Committee on Reports of Officers and Articles of Incorporation and Bylaws — Robert Barry, Chairman, George Baker, Amado Chanco, Claude Koons and Gerald McGowan

House Action: Approved retention of IMS dues for 1982 at their current level of \$275, and commended the Board of Trustees for its effective administration of Society resources.

House Action: Encouraged the Board of Trustees to conduct periodic member opinion surveys; it was requested Blue Shield be treated as a separate entity in future survey questions on third parties.

House Action: Asked the Board of Trustees to assure that data from the forthcoming Iowa Voluntary Cost Containment Committee Patient Day Study be valid and that any conclusions or recommendations coming from the study be in line with the goal of the profession to deliver quality medical care.

House Action: Approved amendment of IMS bylaws to accord resident members the right to vote and to hold office. Urged the Committee on Resident Physicians to continue its deliberations toward the goal of creating a Resident Physician Section.

House Action: Instructed the Standing Committee on Articles of Incorporation and Bylaws to study the IMS organizational structure and the length of terms for Society officers.

House Action: Rejected a proposal calling for the scheduling of the annual meeting of the House of Delegates in late March or early April.

(Please turn to page 283)

Reference Committee on Legislation — John Garred, chairman, William Franey, Thomas Graham, Lyle Fuller and Bruce Trimble

House Action: Instructed the IMS to ask the State Department of Health to require more detailed reporting from state-funded well elderly screening clinics. Detailed accounting of clinic activities is to include (1) all sources of funding, and (2) documentation of compliance with the April 13, 1978, "Standards and Recommendations for Well Elderly Screening Clinics," with particular attention to documentation of physician referral and follow-up activities. Funding of individual well elderly screening clinics should be contingent upon the provision of such information. Pursue appropriate action to assure the State Department of Health receives adequate funding to collect relevant data. Urged rapport with local physicians be established in accordance with 1978 "Standards and Recommendations for Well Elderly Screening Clinics," to include formal approval by the county medical society of a well elderly screening clinic.

House Action: Authorized the IMS to promote and support educational efforts to encourage public eating establishments to voluntarily provide separate areas for smokers and non-smokers.

House Action: Rejected a resolution designating advanced EMTs, advanced EMT-IIs and paramedics as "physician designees."

House Action: Defeated a resolution requesting IMS officers to obtain a legal opinion dealing with the powers of the Board of Medical Examiners so as to reverse a rule of the Board covering the use of certain anorectic agents in the treatment of obesity.

House Action: Directed the IMS Committee on Emergency Medical Services to study the certification of ambulance services and personnel and report its findings to the Executive Council or 1982 House of Delegates.

House Action: Voiced support for educational efforts to inform the public as to the hazards of alcohol and substance abuse, and directed the IMS to back legislation calling for more severe penalties on individuals convicted of operating

a motor vehicle under the influence of alcohol or other drugs.

House Action: Reaffirmed opposition to legislation restricting the dispensing of prescription drugs by a licensed physician, or the delegation of nonjudgmental functions relating thereto.

House Action: Supported the importance and value of the pasteurization of milk.

House Action: Reaffirmed IMS approval of the concept of voluntary screening programs for the detection of newborn genetic and metabolic disorders. Opposed designation of a state agency to be responsible for the initiation, conduct and supervision of *mandatory* screening tests for purposes of discovering genetic and metabolic birth defects.

House Action: Reaffirmed a request made to the American Medical Association calling for appropriate contacts at the national level to encourage a change in the Medicare law to permit reaccumulation of covered care (60 days) in an acute level facility whether the patient is living in an intermediate care facility, for which he or she is financially responsible, or a private home.

House Action: Asked the IMS Medico-Legal Committee to study the question of immediate release of information relating to malpractice litigation.

Reference Committee on Medical Service and Miscellaneous Business — Dennis Walter, chairman, John Fernandez, Dwight Sattler, Gerhard Schmunk and James White.

House Action: Approved the concept of neutral public policy and fair market competition among licensed physicians, and decreed that the potential growth of HMO's not be decided by federal stimulus but by the number of people who prefer this mode of delivery. Called for IMS cooperation in contacts relative to alternate delivery systems and in supplying pertinent reference material. Suggested physicians maintain open lines of communication with business and consumer groups, Blue Cross/Blue Shield, health insurance underwriters and employers concerning alternate delivery systems.

(Please turn to page 285)



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of Iowa

SUMMARY OF 1981 HOUSE OF DELEGATES

House Action: Endorsed in principle and referred to the Subcommittee on Public Assistance proposed changes in Medicaid emerging from President Reagan's economic program.

House Action: Recommended Rabies Immune Globulin and Human Rabies Vaccine be available in hospitals which are not publicly or county funded and do not have a pharmacist on duty 24-hours a day, 7 days a week.

House Action: Directed the IMS Committee on Sports Medicine to study a resolution requesting student athletic physical examinations be required only once during grades 7-9 and once again during grades 10-12.

House Action: Reaffirmed support for legislation mandating the wearing of safety helmets by operators of motorcycles or other motorized two-wheel vehicles.

House Action: Agreed that quality of care and cost containment should be the goal of all physicians and every effort should be made to avoid unnecessary tests.

House Action: Established the following guidelines for referring physicians (1) Provide consultant with a history of the case together with the physician's opinion and outline of treatment; (2) All reports to referring physicians from consulting physicians are to be signed by the consulting physician, and (3) Referring and consulting physicians are to continue in a joint effort to improve their relationship for the betterment of the patient.

House Action: Directed the Board of Trustees to maintain close liaison with the Iowa Foundation for Medical Care Board of Directors and submit a review of the IFMC peer review process to the 1982 House of Delegates. The House also asked the IFMC to improve communications with Iowa physicians.

House Action: Encouraged elimination of all government directed peer review programs including Professional Standards Review Organizations. Agreed IMS should work toward providing patients with high quality care at a reasonable cost. Supported replacement of PSRO with a non-governmental program, emphasizing quality patient care and cost effectiveness.

House Action: Opposed FDA issuance of new rules for drugs which practicing physicians find effective in patient care.

House Action: Requested the Iowa Foundation for Medical Care to evaluate the quality of care provided to nursing home patients by physicians.

House Action: Defeated a resolution requesting guidelines be developed by Iowa Foundation for Medical Care outlining the responsibilities of physicians in caring for nursing home patients.

House Action: Reaffirmed IMS opposition to legislation allowing nurse practitioners to function as independent providers of health care. Independent nurse practitioners are to be guided by the same laws that pertain to physicians' assistants relating to credentials, registration and physician supervision. Urged continued monitoring of any proposed changes in the practice of nursing.

House Action: Opposed any expansion of the physician's assistant training program and requested consideration be given to terminating the physician's assistant training program in Iowa.

House Action: Encouraged appropriate supervision of the physician's assistant to assure high quality medical care. Reminded physicians to submit specific complaints regarding abuses of the program to the Board of Medical Examiners.

House Action: Reaffirmed opposition to the granting of prescription writing authority to physician's assistants.

House Action: Instructed the IMS Committee on Delivery of Health Services to continue monitoring developments relating to the role and utilization of physician's assistants and to maintain communication with the Iowa Physician's Assistants Society; Board of Medical Examiners; University of Iowa Physician's Assistant Program and other interested parties.

The House approved a motion that the actions of the Board of Trustees of the Iowa Medical Society from the date of the last annual meeting to the present be ratified and affirmed. The House acknowledged the outstanding leadership of William R. Bliss, M.D., as president of the Iowa Medical Society. The 1982 session of the IMS House of Delegates was announced for May 1 and 2 at the Marriott Hotel in Des Moines.

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VOX DOCS

Please take a look at this month's Vox Docs question below. Then give us your answer. Send it to **IMS JOURNAL**, 1001 Grand Avenue, West Des Moines, Iowa 50265. Last month's question answer results are shown to the right with several of the comments we received.

"The quality of the generic product is still the big uncertainty." — *J. W. Rathe, M.D., Waverly*

"The pharmaceutical companies should derive profit from their research and production investments, otherwise there is no incentive for new drug development." — *J. E. McGee, M.D., Burlington*

"This is a 'loaded question.' Drugs should be 'up to standards' and only reputable pharmaceutical companies involved, but competition is necessary to keep costs down." — *J. M. Tierney, M.D., Carroll*

"Long term economy will not result from increasing the availability of generic drugs." — *M. R. Saunders, M.D., Des Moines*

LAST MONTH'S QUESTION —

Steps to spur availability of generic drugs have been initiated by the federal government. Brand-name manufacturers generally oppose this. How do you feel on the subject?

EASE REQUIREMENT FOR GENERIC MANUFACTURERS 2%

RETAIN PATENT/OTHER REQUIREMENTS FOR OPTIMUM PUBLIC PROTECTION 98%

"It is the responsibility of the physician, not the government or the pharmacist, to determine generic equivalency of drugs. Ethical manufacturers, through research and development, have produced most of the new drugs in the past generation and they need the profit motive, i.e., patent protection, to continue." — *J. D. Compton, M.D., Edgewood*

"To ease quality control requirements for generic drugs would not only be unfairly discriminatory, but also a step backward in protecting patients from ineffective or unsafe medications." — *J. P. Trotzig, M.D., Akron*

JULY QUESTION FOR IOWA PHYSICIANS

The number of physicians in group practices in the U.S. rose 120% in the past decade, according to preliminary data from the AMA. Does this mean solo practice is doomed to extinction before the end of the century?

- ☐ YES, SOLO PRACTICE IS LIKELY TO BE A RARITY
☐ NO, I THINK, IT WILL SURVIVE IN SOME REASONABLE AMOUNT

Comment, please _____

Name _____


Address _____

(Please Complete & Send to **IMS JOURNAL**, 1001 Grand Avenue, West Des Moines, Iowa 50265)



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Each tablet contains: aspirin, 325 mg; plus codeine phosphate, 30 mg, (Warning — may be habit-forming). 

For the millions of patients who need the potency of aspirin and codeine for their acute pain.

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For the most effective dosage in treating acute pain, begin with... two tablets of Empirin \bar{c} Codeine #2 or #3, every four hours. Titrate downward as pain subsides.

EMPIRIN® with Codeine

DESCRIPTION: Each tablet contains aspirin (acetylsalicylic acid) 325 mg plus codeine phosphate in one of the following strengths: No. 2 — 15 mg, No. 3 — 30 mg, and No. 4 — 60 mg. (Warning — may be habit-forming.) 

CONTRAINDICATIONS: Hypersensitivity to aspirin or codeine.

WARNINGS

Drug dependence: Empirin with Codeine can produce drug dependence of the morphine type and, therefore, has the potential for being abused. Psychic dependence, physical dependence, and tolerance may develop upon repeated administration of this drug and it should be prescribed and administered with the same degree of caution appropriate to the use of other oral, narcotic-containing medications. Like other narcotic-containing medications, the drug is subject to the Federal Controlled Substances Act.

Use in ambulatory patients: Empirin with Codeine may impair the mental and/or physical abilities required for the performance of potentially hazardous tasks such as driving a car or operating machinery. The patient using this drug should be cautioned accordingly.

Interaction with other central nervous system (CNS) depressants: Patients receiving other narcotic analgesics, general anesthetics, phenothiazines, other tranquilizers, sedative-hypnotics, or other CNS depressants (including alcohol) concomitantly with Empirin with Codeine may exhibit an additive CNS depression. When such combined therapy is contemplated, the dose of one or both agents should be reduced.

Use in pregnancy: Safe use in pregnancy has not been established relative to possible adverse effects on fetal development. Therefore, Empirin with Codeine should not be used in pregnant women unless, in the judgment of the physician, the potential benefits outweigh the possible hazards.

PRECAUTIONS:

Head injury and increased intracranial pressure: The respiratory depressant effects of narcotics and their capacity to elevate cerebrospinal fluid pressure may be markedly exaggerated in the presence of head injury, other intracranial lesions or a pre-existing increase in intracranial pressure. Furthermore, narcotics produce adverse reactions which may obscure the clinical course of patients with head injuries.

Acute abdominal conditions: The administration of Empirin with Codeine or other narcotics may obscure the diagnosis or clinical course in patients with acute abdominal conditions.

Allergic: Precautions should be taken in administering salicylates to persons with known allergies: patients with nasal polyps are more likely to be hypersensitive to aspirin.

Special risk patients: Empirin with Codeine should be given with caution to certain patients such as the elderly or debilitated, and those with severe impairment of hepatic or renal function, hypothyroidism, Addison's disease, prostatic hypertrophy or urethral stricture, peptic ulcer, or coagulation disorders.

ADVERSE REACTIONS: The most frequently observed adverse reactions to codeine include light-headedness, dizziness, sedation, nausea and vomiting. These effects seem to be more prominent in ambulatory than in nonambulatory patients and some of these adverse reactions may be alleviated if the patient lies down. Other adverse reactions include euphoria, dysphoria, constipation, and pruritus.

The most frequently observed reactions to aspirin include headache, vertigo, ringing in the ears, mental confusion, drowsiness, sweating, thirst, nausea, and vomiting. Occasional patients experience gastric irritation and bleeding with aspirin. Some patients are unable to take salicylates without developing nausea and vomiting. Hypersensitivity may be manifested by a skin rash or even an anaphylactic reaction. With these exceptions, most of the side effects occur after repeated administration of large doses.

DOSEAGE AND ADMINISTRATION: Dosage should be adjusted according to the severity of the pain and the response of the patient. It may occasionally be necessary to exceed the usual dosage recommended below in cases of more severe pain or in those patients who have become tolerant to the analgesic effect of narcotics. Empirin with Codeine is given orally. The usual adult dose for Empirin with Codeine No. 2 and No. 3 is one or two tablets every four hours as required. The usual adult dose for Empirin with Codeine No. 4 is one tablet every four hours as required.

DRUG INTERACTIONS: The CNS depressant effects of Empirin with Codeine may be additive with that of other CNS depressants. See WARNINGS.



Burroughs Wellcome Co.
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North Carolina 27709



QUESTIONS - ANSWERS

MRS. DWAYNE HOWARD
Sioux City

Mrs. Howard is the wife of a Sioux City urologist. She was installed in May as new president of the Iowa Medical Society Auxiliary.

Congratulations on your installation as Auxiliary president. What really is the major ongoing role of the Auxiliary?

It is a modern woman's privilege and responsibility to be an effective individual who works alongside a physician spouse to make our country a healthier place. Acting in a positive fashion, we can use our independent educational backgrounds to pursue community projects which promote health, preventive medicine, as well as human welfare or health repair.

What are the main projects you have in mind for 1981-82?

There are many projects to work on in our diversified rural/urban state. I hope we can retain and increase IMS support as we try to make our spouses more aware of the need for the Auxiliary. We sell ourselves short too many times and almost apologize for being a part of the medical field. The health field is growing and spouses need to receive the AMA and IMS publications and others, to know good things are happening in medicine.

Our projects in the coming year will include

(1) membership (renewal and inactives), (2) membership of resident and student spouses, (3) legislation — education, (4) AMA-ERF, (5) education: (a) "Shape Up For Life," fitness, nutrition, family and stress; (b) handicapped communication (deaf and blind); (c) health coordinators (blood bank, donor, safety, international health, bio-ethic); school health classes; (6) long range planning for the 80's.

Is the membership of the Auxiliary gaining in numbers? And is the level of interest among members also gaining?

In some states the Auxiliary has increased in numbers. This past year was the first in which we have seen a decrease in Iowa. The interest of our membership depends upon good communications and public relations. Interest can be inspired and membership built if we work at it in many ways, through state and national meetings, leadership workshops, and personal contacts.

What brief comment would you have to encourage physicians to get their spouses active in the Auxiliary?

The Auxiliary is a fortunate group of a few people. The association we have with medicine makes us first-hand partners in professional endeavor. All spouses cannot be active; because of family obligations, time must be spent in that way, time is also given often to church leadership and community involvement, but by retaining Auxiliary membership doctors' spouses can be aware of leadership training sessions and policies which are available through the AMA, state, and county organizations.

Physicians don't have time to explain medical policy to their spouses, but they can share their copies of *American Medical News*, *IMS Journal*, *JAMA*, *Medical Economics*, etc. These are educational tools we need as spouses to help us provide the public with facts on human welfare efforts.

I would certainly recommend every couple (physician/spouse) attend the two-day February workshop in Chicago at least every 5 to 10 years. A couple out in practice for their first year would gain valuable help from an association with so many concerned physicians and spouses.

THINGS YOU SHOULD KNOW

NEW IMS/AETNA SUPERVISOR

Dale Hoing succeeded Dave Heath in June as account supervisor for the IMS/Aetna Liability Insurance Program. Dale is a veteran Aetna employee in Des Moines and is well acquainted with the IMS program. Dale is anxious to arrange fall and winter risk management programs with county societies, hospital medical staffs and specialty groups. He can be contacted by calling 1/800/362-1809 outside Des Moines and 245-5712 in Des Moines.

NEW BS PROCESSING

Activity moves forward at Blue Shield toward 1/1/82 implementation of a further-refined claims processing system. The new approach will continue through EDSF, the Dallas-based firm Blue Shield contracted with last year to process regular claims; Medicare claims have been under EDSF for a number of years. The new system will increase the speed and accuracy of information going both to providers and subscribers. New forms are in the set up stage at present.

MEDICAL EXAMS

The semi-annual administration of the FLEX examination occurred June 16, 17 and 18 in Iowa City under the aegis of the State Board of Medical Examiners.

MEMBER DIRECTORY

Space reservations in the informational section of the 1981-82 IMS Member Directory must be received by the end of July. This special section gives offices/clinics chance to furnish particular information on specialty capacity, address, telephone, etc. Contact IMS for info.

IFMC PREXY

Writing in a recent edition of the Iowa Foundation for Medical Care NEWS, IFMC President John Hess, Jr., reminded readers 10 years have lapsed since physicians established the Foundation as a peer review mechanism. He cited health care as a \$200 billion industry and said, as a consequence, a system of accountability must be provided. "The IFMC believes that physicians can manage the accountability issue better than anyone else," he said.

STATE OF HEALTH CARE

The IMS health assessment questionnaire entitled, "What's the State of Your Well Being?" has appeared widely since its appearance in the November 1980 IMS JOURNAL. It's been used by two institutions in Indiana and was also included recently by Abbott Laboratories in its employee publication.

VARIANCE DATA

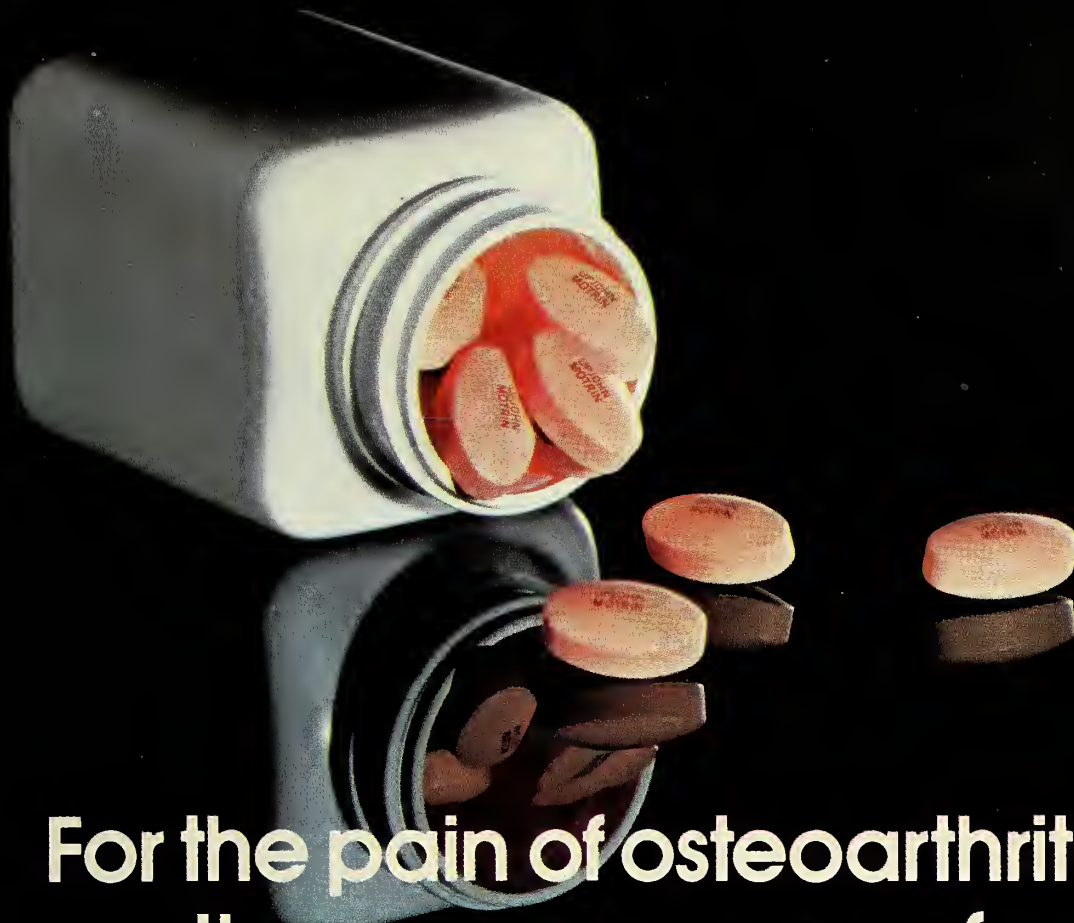
Medication handling (38%) led types of variations reported by Iowa hospitals participating in a Variance Reporting System. This VRS data covers the last half of 1980 and was reported in Quali-Facts, the quality assurance/risk management newsletter of the Iowa Hospital Association. 37% of the variances were categorized as trauma (falls, struck by equipment, burns, etc.). 15% were in the test/treatment area (involving omission, performance, timeliness, procedure, wrong patient, etc.). The figures are based on 6,483 variance reports made to SERVI-SHARE of Iowa.

DXL ON THE GROW

Outpatient DXL benefits are now included in the contracts of 800,000-plus Blue Shield subscribers. Heavy media promotion of DXL has occurred over the past several months.

HOSPITAL DISCHARGES

The Statistical Profile of Iowa, a multi-subject volume prepared by the State Development Commission, has the following as the top five (among 30-plus) reasons for hospital (admission) and discharge: Current Injuries, Deliveries, Other Digestive, Other Respiratory, Heart. The document noted a 66.5% hospital occupancy rate with 5.8 beds per thousand population. Average length of stay was cited at 7.5 days. The data is from 1977 statistics of the American Hospital Association.



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the proven power of

Motrin[®]
ibuprofen, Upjohn
600 mg Tablets
One tablet t.i.d.

Please see the following page for a brief summary of prescribing information.

Upjohn

Motrin® Tablets (ibuprofen, Upjohn)

Contraindications: Individuals hypersensitive to it, or with the syndrome of nasal polyps, angioedema, and bronchospastic reactivity to aspirin, iodides, or other non-steroidal anti-inflammatory agents. Anaphylactoid reactions have occurred in such patients.

Warnings: Peptic ulceration and gastrointestinal bleeding, sometimes severe, have been reported. Ulceration, perforation, and bleeding may end fatally. An association has not been established. *Motrin* should be given under close supervision to patients with a history of upper gastrointestinal tract disease, only after consulting ADVERSE REACTIONS.

In patients with active peptic ulcer and active rheumatoid arthritis, nonulcerogenic drugs, such as gold, should be tried. If *Motrin* must be given, the patient should be under close supervision for signs of ulcer perforation or gastrointestinal bleeding.

Chronic studies in rats and monkeys have shown mild renal toxicity characterized by papillary edema and necrosis. Renal papillary necrosis has rarely been shown in humans treated with *Motrin*.

Precautions: Blurred and/or diminished vision, scotomata, and/or changes in color vision have been reported. If these develop, discontinue *Motrin* and the patient should have an ophthalmologic examination, including central visual fields and color vision testing. **Fluid retention and edema** have been associated with *Motrin*; use with caution in patients with a history of cardiac decompensation or hypertension. *Motrin* is excreted mainly by the kidneys. In patients with renal impairment, reduced dosage may be necessary. Prospective studies of *Motrin* safety in patients with chronic renal failure have not been done. *Motrin* can inhibit platelet aggregation and prolong bleeding time. Use with caution in persons with intrinsic coagulation defects and those on anticoagulant therapy. Patients should report signs or symptoms of **gastrointestinal ulceration** or bleeding, blurred vision or other eye symptoms, skin rash, weight gain, or edema. To avoid exacerbation of disease or adrenal insufficiency, patients on prolonged **corticosteroid therapy** should have therapy tapered slowly when *Motrin* is added. The anti-pyretic, anti-inflammatory activity of *Motrin* may mask inflammation and fever.

Drug interactions. *Aspirin*: used concomitantly may decrease *Motrin* blood levels.

Coumarin: bleeding has been reported in patients taking *Motrin* and coumarin.

Pregnancy and nursing mothers: *Motrin* should not be taken during pregnancy nor by nursing mothers.

Adverse Reactions

The most frequent type of adverse reaction occurring with *Motrin* is gastrointestinal, of which one or more occurred in 4% to 16% of the patients.

Incidence Greater Than 1% (but less than 3%)—Probable Causal Relationship

Gastrointestinal: Nausea,* epigastric pain,* heartburn,* diarrhea, abdominal distress, nausea and vomiting, indigestion, constipation, abdominal cramps or pain, fullness of GI tract (bloating and flatulence); **Central Nervous System:** Dizziness,* headache, nervousness; **Dermatologic:** Rash* (including maculopapular type), pruritus; **Special Senses:** Tinnitus; **Metabolic/Endocrine:** Decreased appetite; **Cardiovascular:** Edema, fluid retention (generally responds promptly to drug discontinuation; see PRECAUTIONS).

Incidence Less Than 1%—Probable Causal Relationship**

Gastrointestinal: Gastric or duodenal ulcer with bleeding and/or perforation, gastrointestinal hemorrhage, melena, gastritis, hepatitis, jaundice, abnormal liver function tests; **Central Nervous System:** Depression, insomnia, confusion, emotional lability, somnolence, aseptic meningitis with fever and coma; **Dermatologic:** Vesiculobullous eruptions, urticaria, erythema multiforme, Stevens-Johnson syndrome, alopecia; **Special Senses:** Hearing loss, amblyopia (blurred and/or diminished vision, scotomata, and/or changes in color vision) (see PRECAUTIONS); **Hematologic:** Neutropenia, agranulocytosis, aplastic anemia, hemolytic anemia (sometimes Coombs' positive), thrombocytopenia with or without purpura, eosinophilia, decreases in hemoglobin and hematocrit; **Cardiovascular:** Congestive heart failure in patients with marginal cardiac function, elevated blood pressure, palpitations; **Allergic:** Syndrome of abdominal pain, fever, chills, nausea and vomiting, anaphylaxis, bronchospasm (see CONTRAINDICATIONS); **Renal:** Acute renal failure in patients with preexisting, significantly impaired renal function, decreased creatinine clearance, polyuria, azotemia, cystitis, hematuria; **Miscellaneous:** Dry eyes and mouth, gingival ulcer, rhinitis.

Incidence Less Than 1%—Causal Relationship Unknown**

Gastrointestinal: Pancreatitis; **Central Nervous System:** Paresthesias, hallucinations, dream abnormalities, pseudotumor cerebri; **Dermatologic:** Toxic epidermal necrolysis, photoallergic skin reactions; **Special Senses:** Conjunctivitis, diplopia, optic neuritis; **Hematologic:** Bleeding episodes (e.g., epistaxis, menorrhagia); **Metabolic/Endocrine:** Gynecomastia, hypoglycemic reaction; **Cardiovascular:** Arrhythmia (sinus tachycardia, sinus bradycardia); **Allergic:** Serum sickness, lupus erythematosus syndrome, Henoch-Schönlein vasculitis; **Renal:** Renal papillary necrosis.

*Reactions occurring in 3% to 9% of patients treated with *Motrin*. (Those reactions occurring in less than 3% of the patients are unmarked.)

**Reactions are classified under "Probable Causal Relationship" (PCR) if there has been one positive rechallenge or if three or more cases occur which might be causally related. Reactions are classified under "Causal Relationship Unknown" if seven or more events have been reported but the criteria for PCR have not been met.

Overdosage: In cases of acute overdosage, the stomach should be emptied. The drug is acidic and excreted in the urine, so alkaline diuresis may be beneficial.

Dosage and Administration: Do not exceed 2400 mg per day. If gastrointestinal complaints occur, administer with meals or milk.

Rheumatoid arthritis and osteoarthritis, including flares of chronic disease: Suggested dosage is 300, 400, or 600 mg t.i.d. or q.i.d. Mild to moderate pain: 400 mg every 4 to 6 hours as necessary for relief of pain.

Caution: Federal law prohibits dispensing without prescription.

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Medical Management of Dental Patients With Bleeding Disorders

JONATHAN C. GOLDSMITH, M.D.

Iowa City, Iowa

While encountered infrequently, the problems associated with dental care of hemophiliacs need to be understood. This presentation provides an overview with notation of recent advances which make the delivery of this care safer and more practical.

DENTAL care for hemophiliacs has long been neglected by both health care professionals and patients. Fear of life threatening hemorrhage resulting from even minor manipulations in the oral cavity has deterred those wishing to provide dental treatment for the patient with an inherited hemorrhagic disorder. Recent advances in knowledge of the hemophiloid disorders have made it safe and practical to deliver dental care as part of a comprehensive regimen.

There are several reasons for the association between dental manipulations and hemor-

rhagic sequelae. First, oral anesthesia, restorations, or extractions may represent the initial hemostatic challenge to those with milder variants of hemophilia. Even in those ultimately demonstrated to have clinically moderate and severe disease, oral medical care may be the affected individual's first surgical procedure. A second reason for the close association between hemorrhage and dental procedures is the high degree of visibility of postoperative blood loss and the threat to airway maintenance. Thirdly, the oral mucosa has significant fibrinolytic activity which predisposes to late hemorrhage and delayed healing as a consequence of dissolution of both normal and defective clots.¹ Diagnostic and treatment mo-

The author is associated with the Division of Hematology-Oncology, Department of Internal Medicine, University of Iowa College of Medicine. This study is supported in part by a grant from the American Lung Association and grant #MCB-190001-05-0 from the Public Health Service — Maternal and Child Health.

THE SCANLON MEDICAL FOUNDATION/IOWA MEDICAL SOCIETY HAS DESIGNATED THIS ARTICLE
AS THE HENRY ALBERT SCIENTIFIC PRESENTATION FOR THE MONTH OF JULY 1981

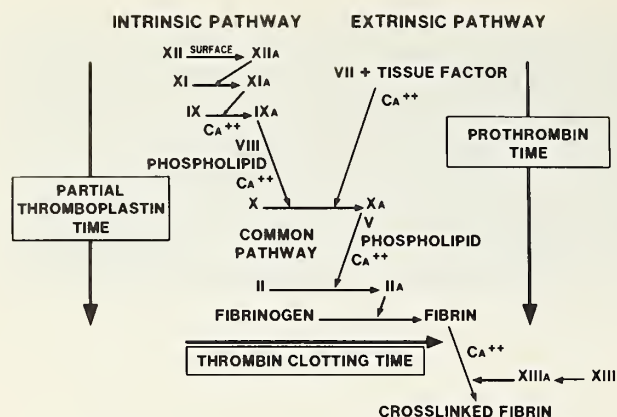


Figure 1. Schematic representation of the Cascade Hypothesis of blood coagulation. The partial thromboplastin time assesses the intactness of the Intrinsic and Common Pathways. The prothrombin time evaluates the Extrinsic and Common Pathways. The thrombin clotting time is affected by qualitative and quantitative abnormalities of fibrinogen and the presence of inhibitors of fibrinogen conversion and fibrin polymerization. Specific assays are required to detect abnormalities of factor XIII.

dalities now available make dental care feasible and safe for patients with inherited bleeding disorders.

APPROACH TO THE PATIENT

Medical History. Prior to offering dental care, it is essential to elicit historical information from the patient regarding hemostatic integrity. Specifically, one should inquire about types of previous hemorrhage, family history, drug history, transfusion history, menstrual history in females, and hemorrhage or delayed healing after prior dental and surgical procedures. The timing of hemorrhage, immediately following surgery or delayed for several days, and the requirement for transfusion of blood products are important bits of historical data. In known hemophiliacs on home therapy it is important to ask about the effectiveness of administered concentrate in terminating hemorrhagic episodes. Ineffectiveness of promptly administered replacement therapy may be the first clue to the development of an inhibitor to a coagulation factor that would complicate medical management.

Physical Examination. Physical examination should include evaluation of the joints for evidence of deformity, effusion, hypermobility, or synovial thickening consistent with previous hemarthroses or inherited disorders of connective tissue. The skin and mucous mem-

branes should be examined for the presence of petechiae, purpura, ecchymoses, telangiectasia and elasticity. The size of existing cutaneous hemorrhagic lesions should be carefully measured. Scars from prior surgery may offer a clue regarding delayed or poor wound healing. Other aspects of a thorough physical examination should not be neglected.

TABLE 1
HEMOSTASIS SCREENING TESTS

Prothrombin time
Partial thromboplastin time
Thrombin clotting time
Bleeding time
Platelet count
Clot stability test

Laboratory Evaluation. Laboratory testing may be of a confirmatory nature in patients carrying a diagnosis of a bleeding disorder or diagnostic when no formal evaluation has been previously performed. Every patient suspected of having a hemostatic defect should have a prothrombin time, partial thromboplastin time (PTT), thrombin clotting time (TCT), platelet count, bleeding time and clot stability test (Table 1). The one stage prothrombin time (PT) assesses the extrinsic and common pathways of the cascade hypothesis of blood coagulation (Figure 1). Patients with functional deficiencies of factor VII (Proconvertin), factor X, (Stuart), factor V (Proaccelerin), factor II (Prothrombin), or fibrinogen may have a prothrombin time 3 seconds or longer than the control. The PTT measures the integrity of the intrinsic and common pathways of coagulation. A deficiency in the plasma activity of factor XII (Hageman), factor XI (Plasma Thromboplastin Antecedent), factor IX (Plasma Thromboplastin Component), factor VIII (Anti-Hemophilic Factor), factor X, factor V, factor II or fibrinogen will prolong the PTT 5 to 10 seconds beyond the control. A three second or longer prolongation of the TCT is a result of a functional deficiency in fibrinogen, circulating fibrin or fibrinogen degradation products, anticoagulants or substances such as immunoglobulins or abnormal fibrinogens interfering with fibrin monomer aggregation. The bleeding time performed by trained laboratory person-

nel using reproducible methods is the best available *in vivo* test of platelet function, although very rare qualitative disorders may be overlooked.² Both qualitative and quantitative platelet abnormalities result in a prolongation of the bleeding time (Figure 2) and there-

TABLE 2
MIXING EXPERIMENT

Test Sample	Activated PTT (sec)
Normol pooled (NP) plasma	32
Hemophilio A plasma	216
NP + Hemaphilio A (1:1)	38
NP + Hemophilio A with inhibitor (1:1)	79

fore a platelet count should be performed simultaneously. Clot stability tests are used to determine factor XIII (fibrinoligase) activity. Normal clots are insoluble and stable in either one molar monochloroacetic acid or 5 molar urea. Under these conditions fibrin clots from patients with a congenital deficiency of factor XIII dissolve.

Abnormal coagulation screens are not always diagnostic of a bleeding disorder. Prolongation of the PTT may be a consequence of factor XII deficiency which is not a cause of a clinical hemorrhagic state. Defects in the so-called contact system (Kininogen, Prekallikrein) also result in a prolonged PTT but no clinical bleeding.³ Nonspecific circulating anticoagulants, usually immunoglobulins, may also cause a prolongation of the PTT and less often the prothrombin time but not be associated with defective hemostasis.⁴

Normal coagulation screens do not rule out a mild bleeding disorder as 20-25% of a clotting factor, when present as a solitary deficiency, is sufficient to normalize the PTT or prothrombin time. The history is important in these cases to direct the clinician to order specific clotting factor assays.

Circulating anticoagulants (inhibitors) to factor VIII occur in approximately 15% of patients with classical hemophilia (factor VIII deficiency, hemophilia A).⁵ These are detected when the patient's plasma is mixed with normal plasma and the PTT fails to correct to normal (Table 2). An incubation of the mixed plasmas at 37°C for 1 or 2 hours is often necessary to demon-

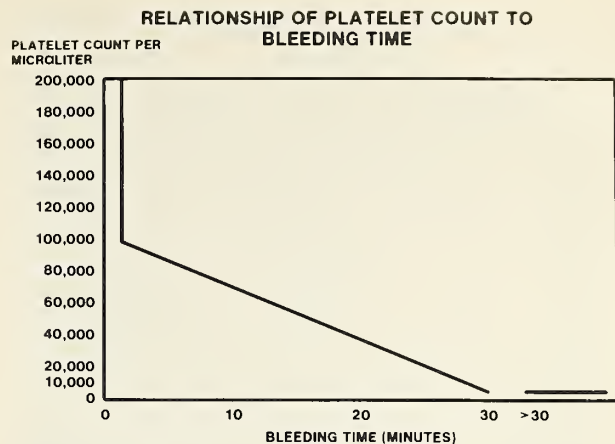


Figure 2. The bleeding time is a linear function of the platelet count when the count is less than 100,000/ μ L. Superimposed qualitative platelet defects alter this relationship. (Modified from reference 21).

strate the presence of such an inhibitor *in vitro*.⁶

REPLACEMENT THERAPY

The most common bleeding disorders requiring therapy are hemophilia A, hemophilia B, von Willebrand's disease and qualitative or quantitative platelet abnormalities.

Hemophilia A. Normal plasma contains 1.0 unit of factor VIII/ml (defined as 100%). Patients with severe hemophilia have <0.01 units/ml (defined as <1%). For practical purposes, these patients can be assumed to have no circulating factor VIII. In extensive dental procedures where inferior alveolar nerve blocks are administered for anesthesia or when multiple extractions are planned, the factor VIII level should be raised to at least 0.75 units/ml (75%) immediately preoperatively and confirmed by a specific assay for factor VIII. 0.5 units/ml (50%) is an appropriate therapeutic goal when less extensive procedures are planned.

The dose of factor VIII can be calculated based on the patient's plasma volume (the space of distribution of factor VIII) and the number of units of factor VIII in the contemplated replacement source. A good estimate of the plasma volume can be derived from the formula:

$$\text{plasma volume (ml)} = \text{body weight (kg)} \times 50.0$$

(Please turn to page 294)

A 60 kg man with <0.01 units/ml ($<1\%$) factor VIII will require 2250 units of factor VIII to achieve a level of 75% assuming that the blood product administered does not significantly expand his plasma volume.

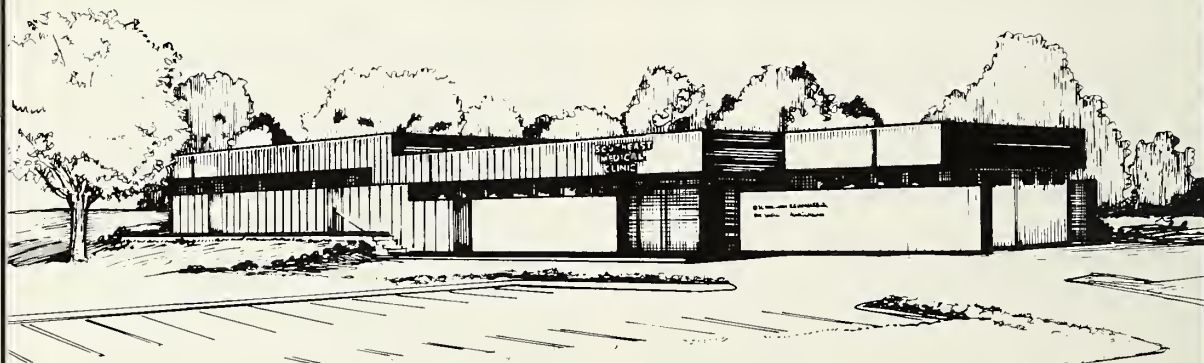
$$\begin{array}{rclcl} \text{Weight} & & \text{Desired} & & \text{Units Factor} \\ (\text{kg}) & \times 0.5^* \times & \text{Final \%} & = & \text{VIII Required} \\ (60) & \times 0.5 \times & 75 & = & 2250 \text{ units} \end{array}$$

* Decimal point rearranged to allow the use of a whole number for desired percentage.

A mildly affected patient with 0.15 units/ml (15%) factor VIII would require only 1800 units of factor VIII to achieve the same level of 75% under the given set of assumptions as, in effect, he needs to be raised 0.60 units/ml (60%) which is the difference between 0.15 units/ml and 0.75 units/ml.

$$\begin{array}{rclcl} \text{Weight} & & \text{Desired} & & \text{Units Factor} \\ (\text{kg}) & \times 0.5 \times & \text{Final \%} & = & \text{VIII Required} \\ (60) & \times 0.5 \times & 60 & = & 1800 \text{ units} \end{array}$$

Factor VIII can be administered in several forms. Plasma contains 1.0 unit of factor VIII/ml or 225 units/bag. Cryoprecipitate contains 5-10 units/ml or 80-100 units/bag of 10-15 ml. Lyophilized factor VIII (e.g. Factorate®, Hemophil®, Koate®, Profilate®) concentrates contain 250 to 500 units/bottle reconstituted to 20-30 ml. Volume constraints limit the use of plasma as a replacement vehicle because infusions of greater than four units of plasma (900 units of factor VIII) in a 12-18 hour period may result in circulatory embarrassment. Also, the volume of administered plasma must be included in the final estimation of the patient's plasma volume which results in a lower final factor VIII concentration than calculated initially. Cryoprecipitate or plasma are still the preferred forms of replacement therapy for patients with mild hemophilia in view of the risk of hepatitis transmission with factor VIII concentrates and the infrequent or rare need for therapy in this patient group.⁷ Large doses of lyophilized concentrate also carry the risk of inducing hemolysis in patients with blood



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groups other than O (H), as these concentrates are made from plasma pooled from donors of all blood groups and may contain large amounts of anti-A and anti-B immunoglobulin.⁸

Uncomplicated procedures may not require additional infusions as factor VIII has an *in vivo* half life of 8-12 hours. These procedures can be safely performed on an out-patient basis. The occurrence of delayed hemorrhage, a hallmark of mild as well as severe hemophilia, previously required prolonged hospitalizations and continual infusion of factor VIII material for 8-10 days postoperatively. The need for such extended courses of in-hospital therapy has been greatly diminished by the oral administration of Epsilon-Aminocaproic Acid (EACA), a pharmacologic inhibitor of fibrinolysis.⁹ Use of EACA allows clots formed to remain intact until fibroblast ingrowth and wound healing has occurred. Although higher doses have been employed, 50 mg of EACA/kg of body weight given orally in the liquid form every 6 hours beginning immediately prior to surgery and continued for 10 days, is a sufficient dose.^{10, 11}

Meticulous local surgical care should be practiced. Extraction sites should be packed with either topical thrombin or avitene® (microcrystalline collagen) to promote platelet aggregation and formation of a primary hemostatic plug.¹² Also, patients should be advised to refrain from activities such as smoking and using straws that create a negative intra-oral pressure. These forces will disrupt clots.

Hemophilia B. Hemophilia B (Christmas Disease) or factor IX deficiency is clinically indistinguishable from hemophilia A. Specific factor assays are required to differentiate these two disorders. Several differences exist in replacement therapy for patients congenitally deficient in factor IX compared to those with classical hemophilia.

Factor IX is distributed into a space 2.5 times greater than the patient's plasma volume in contrast to factor VIII which is distributed into the plasma volume (*vide supra*). In contrast to factor VIII, factor IX has a plasma half life of 20-24 hours.¹³

Replacement therapy can be accomplished by the infusion of plasma or factor IX concentrate (prothrombin complex concentrate). Plasma contains one unit of factor IX/ml. Factor IX

is *not* concentrated in cryoprecipitate beyond plasma levels. Cryoprecipitate offers no advantage in the treatment of patients with hemophilia B and its use is therefore inappropriate. The lyophilized commercial factor IX concentrates (Konyne® and Proplex®) also contain significant quantities of factor II and X activity and variable amounts of factor VII activity. The risk of hepatitis transmission with factor IX concentrates is significant. Some lots of factor IX concentrates pose the additional risk of inducing inappropriate thrombosis due to high concentrations of activated procoagulants or perhaps platelet membrane phospholipid.¹⁴

In general, severely affected patients with less than 0.01 units/ml (<1%) plasma factor IX activity undergoing extensive dental procedures are raised to a plasma factor IX level of 30-50% of normal using non-thrombogenic prothrombin complex concentrates. These concentrates are identified by manufacturers as having longer non-activated partial thromboplastin (Kingdon) times. A useful formula to calculate the number of units of factor IX required is:

Body Weight		Desired		Units Factor
(kg)	$\times 1.25 \times$	Final%	=	IX Required
60	$\times 1.25 \times$	30%	=	2250 units

Patients with milder disease and infrequent need for transfusions should receive fresh frozen plasma. In view of the long half life of factor IX, it is often useful to begin infusions of plasma 24-36 hours before surgery to allow multiple units of plasma to be administered without producing circulatory overload or to employ plasma exchange to achieve a level of 20-30% of normal. The extent of surgery and the patient's clinical condition will dictate the need for subsequent infusions. This need can be diminished by the use of EACA for 8-10 days postoperatively and topical hemostatic measures (such as thrombin or collagen).

Hemophilia A patients with inhibitors to factor VIII. Elective dental procedures should not be undertaken in this patient population. When extractions or lesser procedures are necessary 2 approaches are practical but do not ensure hemostasis in the sense that replacement therapy normally does. When inhibitor titers are

(Please turn to page 296)

not high (less than 20 Bethesda Units), the inhibitor can be overwhelmed *in vivo* by the infusion of large amounts of factor VIII concentrate. Circulating levels of factor VIII can then be maintained by continuous infusion of factor VIII.¹⁵ An anamnestic response in the titers of factor VIII antibody occurs in most patients 3 to 5 days after the infusion is initiated making further therapy impossible. An initial or subsequent therapeutic alternative in these patients with circulating anticoagulants to factor VIII is the administration of prothrombin complex concentrates (PCC) containing material that bypasses the factor VIII inhibitor.¹⁶ This material with a shorter non-activated PTT (Kingdon time) may contain activated factor VII, IX and/or possibly X. 75 units of factor IX/kg body weight is administered over 30-60 minutes by slow bolus injection. Dental procedures should begin immediately after infusion because hemostasis resulting from PCC infusion is of brief duration. Although variations in several laboratory parameters have been described after infusions of PCC including shortening of the prothrombin time and PTT, none of these alterations correlate with the achievement of clinical hemostasis.¹⁷ Therefore laboratory monitoring of PCC therapy in patients with factor VIII inhibitors is inadequate. The topical hemostatic agents thrombin and collagen are appropriate for these patients. However the use of EACA is strictly contraindicated. Inhibition of fibrinolysis by EACA will impair the only defense mechanism available should inappropriate thrombosis occur in a vital segment of the circulation as a result of the infusion of activated PCC. Fatal complications may occur under these circumstances.

Von Willebrand's Disease. Von Willebrand's Disease is an autosomal dominant inherited disorder clinically manifested by surface and postoperative hemorrhage. In laboratory determinations, defects in both the function and structure of factor VIII are identifiable as well as a prolonged bleeding time. Replacement therapy should be in the form of plasma or cryoprecipitate. Lyophilized factor VIII concentrates often lack the "von Willebrand Factor" necessary for correction of the bleeding time and are therefore inappropriate.¹⁸ Eight to 10 bags of cryoprecipitate given immediately

preoperatively will shorten the bleeding time in most patients to normal for several hours as well as providing a delayed but prolonged hyperresponse of factor VIII coagulant activity in the recipient's plasma. Reinfusions at 4 to 12 hour intervals may be needed on the day of surgery as dictated by the patient's clinical condition. Laboratory parameters that correlate best with the clinical effect are the bleeding time and the von Willebrand Factor (Ristocetin Cofactor). Adjunctive therapy with EACA for 8 to 10 days to inhibit fibrinolysis and local socket therapy with thrombin or avitene® will shorten hospitalizations and prevent delayed hemorrhage.

Qualitative Platelet Abnormalities. Patients with normal platelet counts and prolonged bleeding times may have congenital or acquired qualitative disorders. Historical information will often clarify the situation. If doubt remains, retesting following a 2 week medicine-free interval may prove useful. The nature of these platelet defects is often elucidated by formal platelet aggregation studies employing collagen, ADP and epinephrine as well as tests for adhesiveness, clot retraction and prothrombin consumption (serum prothrombin time). Storage pool disease, congenital disorders of platelet membrane glycoproteins (e.g. Glanzmann's Thrombasthenia, Bernard Soulier Syndrome), and defects in the release of platelet phospholipid (PF-3) can be differentiated. Aspirin-like defects can also be identified. These distinctions are important in terms of genetic counselling.

Treatment of qualitative platelet disorders consists of the administration of platelet "concentrate" equal to 6 single donor units. Correction of the bleeding time preoperatively should be documented. The local hemostatic agents thrombin or avitene® and the anti-fibrinolytic substance EACA for 8 to 10 days postoperatively are useful ancillary measures. Patients with long antecedent transfusion histories may require HLA similar platelets (from a non-family member in the congenital disorders) or PLA1⁻ platelets in the case of thrombasthenia.^{19, 20} Dental surgery may be complicated in these latter groups of patients due to unavailability of appropriately matched platelet concentrate. Elective procedures are not practical in such individuals.

Quantitative Platelet Abnormalities. While there are congenital disorders characterized by

thrombocytopenia such as thrombocytopenia absent radii (TAR) syndrome and Bernard Soulier Syndrome, most quantitative platelet abnormalities are acquired. Although patients with rapid platelet turnover may have greatly decreased platelet counts with a normal or near normal bleeding time, as occurs in Idiopathic Thrombocytopenic Purpura (ITP), in general the bleeding time correlates with the platelet count. When the platelet count is $<20,000/\mu\text{L}$, the bleeding time usually exceeds 25 minutes and "wet purpura" (mucous membrane petechiae) are present.

Patients with thrombocytopenia may have complicating medical conditions such as acute leukemia that may preclude elective dental procedures. However, patients with severe but stable thrombocytopenia, as occurs in aplastic anemia, may require and be good candidates for dental care. Extensive medical evaluation is often necessary to decide if the thrombocytopenic patient is a candidate for dental treatment.

If the patient has not been previously sensitized to platelet born antigens, then the equivalent of 6 units of random donor platelets should be administered preoperatively. The therapeutic goal is reduction of the bleeding time to normal. However, a platelet count in excess of $50,000/\mu\text{L}$ is also desirable. Retransfusion may be required postoperatively. Local hemostatic agents (thrombin or collagen) should be applied at the time of surgery and oral EACA should be employed for 8 to 10 days postoperatively to inhibit fibrinolysis.

ACKNOWLEDGMENT

The author wishes to express his appreciation to Wendy Marsh for her assistance in the preparation of the manuscript.

REFERENCES

The references noted in this paper are available on request either from the author or the JOURNAL OF THE IOWA MEDICAL SOCIETY.

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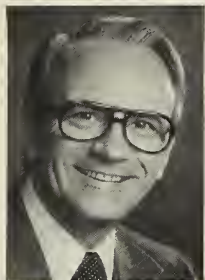
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COMMENTING EDITORIALY

MARION E. ALBERTS, M.D.
SCIENTIFIC EDITOR

SO FEW FOR SO MANY

THIS ISSUE of the JOURNAL contains a summary of actions taken by the 1981 IMS House of Delegates when it met May 2 and 3. These various actions (ranging from a mandate for motorcyclists to wear headgear to concerns over the continued need for physician's assistants) come down as policies to be followed by the Society in the legislative and other arenas. These actions emerge out of the representative process where a few are elected to represent many.

There are 3,020 members of the Iowa Medical Society. An established formula provides for the selection of 223 physicians out of this total to represent their county medical societies as delegates to the House. These delegates are also meant to be paired with an alternate.

We entrust these delegates and the IMS officers with the authority to act in our behalf. They are chosen for their interest, ability, experience, willingness and often availability. Gratitude is due those 1981 delegates who labored for two days in May to discuss and vote on the resolutions/reports submitted.

But, where were the rest of the delegates?

As noted, there are 223 delegates (and an approximate similar number of alternates). At the first House session 139 delegates answered the roll. The second session had 141 delegates. Many delegates come long distances and give up both professional and leisure time (and this year with favorable weather outside). Lots of them serve unselfishly year after year. We salute those who so serve. This is an excellent and important service.

More member physicians should become involved as delegates. This is a Society of and for all members. Thus, all members should feel committed to give of their time and interest to the process of establishing policy, setting priorities and doing all those things which are in the interest of the public and the profession.

We have a devoted and active Board of Trustees. I have the enviable opportunity to see and know of many of the duties performed by these officers. My frequent visits to IMS headquarters give me a chance to observe the activity. We are in their debt, fellow IMS members; they work hard for us.

Another group of persons remain too often unrecognized. We owe, also, a debt of gratitude to the IMS administrative staff. I am privileged to visit and work with these individuals regularly. They are dedicated to Iowa physicians and to the program of the Society. They work conscientiously and pursue a busy schedule. Too often we neglect to thank them. So, I do that now for all IMS members; thank you, all of you, for working so well for us. — M.E.A.

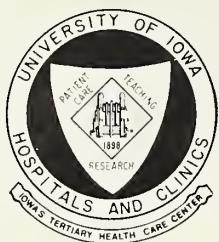


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DRUG THERAPY REVIEW



UNIVERSITY OF IOWA HOSPITALS AND CLINICS

REYNOLD SPECTOR, M.D., Editor

Editor's Note — The toxicity of the common cardiovascular drugs is substantial. Drs. McEniry and Skorton have reviewed the Adverse Reactions to Cardiovascular Drugs. Part II will appear in the August 1981 issue.

ADVERSE REACTIONS TO CARDIOVASCULAR DRUGS (Part I)

AN ADVERSE DRUG REACTION is any deleterious and undesired effect of a medication given with therapeutic intent. One of several mechanisms may be responsible, and the reaction may be: (1) allergic, (2) caused by a dose-related direct effect of the drug on the target organ or other organs, or (3) due to an idiosyncratic reaction, sometimes on a genetic basis.¹

When starting any drug therapy, the frequency and severity of adverse reactions must

This information for Iowa physicians is furnished and sponsored by the University of Iowa Hospitals and Clinics.

always be considered in conjunction with the likelihood and desirability of a given therapeutic effect. When adverse reactions are very rare or very mild, a drug may be reasonably given even when a beneficial effect is either unproven or unlikely. However, when adverse reactions are frequent, severe, or lethal, the drug must be given only for clear indications in which a therapeutic effect is not only likely, but clearly beneficial. Drugs used in treatment of cardiac disease frequently have a low therapeutic index (benefit/risk ratio) and are sometimes used in situations in which the therapeutic benefits are unlikely or uncertain and outweighed by the risks. We will briefly review the major cardiac and noncardiac adverse reactions to selected cardiovascular drugs.

DIGITALIS

Digitalis is probably the most frequent cause of serious adverse drug reactions. The frequency of toxicity has been 10-30% in hospitalized patients. In recent years with the use of digoxin drug levels and better understanding of dosing regimens, the toxicity of digitalis has declined to about 10% in hospitalized patients.²

The major morbidity and mortality from digitalis is from cardiac arrhythmias and heart block. Almost any cardiac arrhythmia may occur secondary to digitalis.³ The most common are ventricular premature beats and AV nodal rhythms (either AV nodal escape or nonparoxysmal AV nodal tachycardia). Supraventricular tachycardia, often with AV block, is also seen. First degree AV block is considered digitalis effect by most authors; an early sign of toxicity with likelihood of progression to higher degrees of AV block by others.

Worsening of congestive heart failure may be a manifestation of digitalis toxicity and may be precipitated by a dysrhythmia but also may be caused by a direct effect on the myocardium. Toxicity should be considered in any patient on digitalis with worsening of congestive heart failure.

Noncardiac manifestations of digitalis toxicity include gastrointestinal, neurologic, and ophthalmologic signs and symptoms. Gastrointestinal symptoms most commonly include anorexia, nausea, and vomiting. Neurologic symptoms are nonspecific. Headache, confusion, depression, and other mental status changes may be the first symptoms of intoxication. Uncommon symptoms are frank

DRUG THERAPY REVIEW

(Continued from page 300)

psychosis with hallucinations, neuralgias, and seizures. Ophthalmologic complaints related to digitalis are also varied; they occur in about 10% of toxic patients. Changes in color vision, especially yellow or green halos may be pathognomonic but are uncommon. Visual blurring and decreased visual acuity are the most frequent ocular complaints.

The most important manifestations of digitalis intoxication are cardiac; the others are important as clues to the possibility of toxicity. The prevention of digitalis intoxication depends upon a knowledge of the clinical pharmacology of the drug and factors which may predispose to toxicity.

The major route of excretion of digoxin is renal. The major factors which may effect the clearance of digoxin are creatinine clearance, body weight, and age. Patients with deteriorating or fluctuating renal function are at particular risk for developing digoxin intoxication. Another recently recognized cause of elevated serum levels of digoxin and increased risk of toxicity is an interaction with quinidine. Quinidine decreases renal clearance of digoxin and increases steady state levels. Patients begun on quinidine while on maintenance digoxin should have a 50% reduction of the maintenance dose.⁴

Digitoxin is cleared mainly by the liver and only to a minor degree by the kidneys. An interaction with quinidine is controversial. However, it has a prolonged half-life which may prolong toxicity once developed.

Factors which have been implicated in causing increased risk of digitalis toxicity without effecting serum levels include: hypokalemia, hypercalcemia, diuretic use, severe heart failure, hypothyroidism, hypomagnesemia, and chronic lung disease (especially during acute exacerbations).

For the diagnosis of digitalis toxicity, serum digitalis levels have limited value because of a large crossover between toxic and therapeutic ranges. They are useful to establish that a patient is taking digitalis. A subtherapeutic level of digoxin (i.e. $< .8$ ng/ml) suggests a very low

(Please turn to page 302)

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Each gram of Anusol-HC Cream contains hydrocortisone acetate, 5.0 mg; bismuth subgallate, 22.5 mg; bismuth resorcin compound, 17.5 mg; benzyl benzoate, 12.0 mg; Peruvian balsam, 18.0 mg; zinc oxide, 110.0 mg; also contains the following inactive ingredients: propylene glycol, propylparaben, methylparaben, polysorbate 60 and sorbitan monostearate in a water-miscible base of mineral oil, glyceryl stearate and water.

Anusol-HC Suppositories and Anusol-HC Cream help to relieve pain, itching and discomfort arising from irritated anorectal tissues. These preparations have a soothing, lubricant action on mucous membranes, and the antiinflammatory action of hydrocortisone acetate in Anusol-HC helps to reduce hyperemia and swelling.

The hydrocortisone acetate in Anusol-HC is primarily effective because of its antiinflammatory, antipruritic and vasoconstrictive actions.

Indications and Usage: Anusol-HC Suppositories and Anusol-HC Cream are adjunctive therapy for the symptomatic relief of pain, itching and discomfort in: external and internal hemorrhoids, proctitis, papillitis, cryptitis, anal fissures, incomplete fistulas, pruritus ani and relief of local pain and discomfort following anorectal surgery.

Anusol-HC is especially indicated when inflammation is present. After acute symptoms subside, most patients can be maintained on regular Anusol® Suppositories or Ointment.

Contraindications: Anusol-HC Suppositories and Anusol-HC Cream are contraindicated in those patients with a history of hypersensitivity to any of the components of the preparations.

Warnings: The safe use of topical steroids during pregnancy has not been fully established. Therefore, during pregnancy, they should not be used unnecessarily on extensive areas, in large amounts or for prolonged periods of time.

Precautions: **General:** Symptomatic relief should not delay definitive diagnoses or treatment.

Prolonged or excessive use of corticosteroids might produce systemic effects.

If irritation develops, Anusol-HC Suppositories and Anusol-HC Cream should be discontinued and appropriate therapy instituted.

In the presence of an infection the use of an appropriate antifungal or antibacterial agent should be instituted. If a favorable response does not occur promptly, the corticosteroid should be discontinued until the infection has been adequately controlled.

Anusol-HC is not for ophthalmic use.

Pregnancy

See "WARNINGS"

Pediatric Use

Care should be taken when using the corticosteroid hydrocortisone acetate in children and infants.

Dosage and Administration: Anusol-HC Suppositories—

Adults: Remove foil wrapper and insert suppository into the anus. Insert one suppository in the morning and one at bedtime for 3 to 6 days or until inflammation subsides. Then maintain comfort with regular Anusol Suppositories.

Anusol-HC Cream—Adults: After gentle bathing and drying of the anal area, remove tube cap and apply to the exterior surface and gently rub in. For internal use, attach the plastic applicator and insert into the anus by applying gentle continuous pressure. Then squeeze the tube to deliver medication. Cream should be applied 3 or 4 times a day for 3 to 6 days until inflammation subsides. Then maintain comfort with regular Anusol Ointment.

NOTE: If staining from either of the above products occurs, the stain may be removed from fabric by hand or machine washing with household detergent.

How Supplied: Anusol-HC Suppositories—boxes of 12

(N 0071-1089-07) and boxes of 24 (N 0071-1089-13) in silver foil strips with Anusol-HC printed in black.

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DRUG THERAPY REVIEW

(Continued from page 301)

possibility of digoxin toxicity; levels of greater than 3.0 ng/ml are frequently associated with toxicity.

The treatment of digitalis toxicity includes immediate cessation of the drug upon suspicion of toxicity. Drug withdrawal alone is often adequate therapy. Patients may require monitoring. Potassium is effective for a wide range of digitoxic rhythms but should not be given for heart block. Atropine and temporary pacing may be used for heart block. Lidocaine and phenytoin may be effective in serious digitalis-related tachyarrhythmias.

DIURETICS

The most commonly used agents are the thiazide diuretics and furosemide, and they share most of their adverse effects.⁵ Cardiovascular toxicity is largely related to the danger of excessive volume depletion, leading to hypotension and circulatory collapse. In patients on digitalis glycosides, the loss of potassium associated with these agents may precipitate digitalis toxicity. Other important metabolic consequences of diuretic use include hypochloremic metabolic alkalosis, hypomagnesemia, hyponatremia, hyperglycemia, hyperuricemia (occasionally with precipitation of acute gout), and prerenal azotemia. When used in the precarious patient with edema related to hepatic cirrhosis, hepatic coma and renal insufficiency may be precipitated. Less common side effects of these agents include skin rash, photosensitivity, pancreatitis, transient hearing loss, and bone marrow depression.

NITRATES

Nitroglycerin has long been, and continues to be, the mainstay of the outpatient treatment of acute myocardial ischemia (angina pectoris). Although considerable controversy has attended the efficacy of the longer-acting nitrates, there is currently an increase in the use

of agents such as isosorbide dinitrate for prevention of predictable angina pectoris. Topical nitroglycerin ointment has also enjoyed increased use recently. Long-acting preparations have also been advocated and shown effective as preload reducing agents in the treatment of refractory congestive cardiac failure.

Serious side effects of these agents are uncommon, but mild-to-moderate symptoms commonly accompany their use. The peripheral vasodilatation induced by nitrates causes throbbing headaches, flushing, and postural hypotension. This blood pressure effect may have serious consequences for cerebral and cardiac perfusion in some patients. Dizziness, palpitations, and reflex tachycardia are sometimes seen. An interesting early observation in industrial workers exposed to heavy doses of nitrates was the precipitation of angina pectoris upon "withdrawal" from the industrial environment.

NITROPRUSSIDE

Sodium nitroprusside has an important role as a parenteral agent used in the treatment of hypertensive crisis, dissecting aortic aneurysm, and as a preload and afterload reducing agent in cardiogenic shock and refractory cardiac failure.³ Toxicity related to peripheral vasodilatation, similar to that seen with nitrates, may also be seen with nitroprusside. These effects, including hypotension, are rapidly reversible after cessation of the drug infusion. An interesting additional toxicity seen with nitroprusside is related to the generation of hydrocyanic acid, which is metabolized to thiocyanate. When thiocyanate levels exceed 6 mg/dl, an increased risk in renal failure, several adverse effects can be recognized, including psychosis, muscle twitching, abdominal discomfort, and frank seizures. Hypothyroidism is an unusual, but reported, side effect of thiocyanate toxicity. Methemoglobinemia and vitamin B₁₂ deficiency may be seen with nitroprusside. — DAVID W. MCENIRY, M.D., *Fellow in General Medicine*, and DAVID J. SKORTON, M.D., *Assistant Professor of Medicine, Department of Internal Medicine, University of Iowa College of Medicine*.

REFERENCES

The references noted will be carried with the Part II concluding portion of this discussion.

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STATE DEPARTMENT/ PUBLIC HEALTH

PUBLIC HEALTH NURSING ADVISORY COMMITTEES

IN THE MARCH 1981 issue of the JOURNAL, we cited the service of physicians on their local boards of health. In this issue, we want to recognize another area of community investment by Iowa physicians through service on public health nursing advisory committees.

Advisory committees for public health nursing agencies have been in existence for several years. Some recent changes have increased their visibility and effectiveness. Increased emphasis on advisory committees by "Medicare" has resulted in their becoming an invaluable asset to local public health agencies. In addition, a series of leadership conferences using the expertise of the Iowa State University Extension Service has clarified the roles and processes for advisory committees and boards of health.

Advisory committee members who are appointed by the board of health, are selected because of their expertise in health, business, management, communications, law, labor, etc. The physicians serving in this capacity have been of particular value because of their health related skills, plus their working knowledge of community health facilities and patient needs.

This information on public health matters is furnished and sponsored by the Iowa State Department of Health.

The close working relationship that is developing between boards of health, advisory committees, and staff has led to more effective delivery of services. The advisory committees provide valuable objective professional expertise to local boards of health concerning their public health nursing agencies. Their ongoing evaluations ensure quality services.

The surveyor of home health agencies for the Medicare Program reports there is an added dimension of professionalism in the agencies where an active advisory committee is functioning.

This has happened by action of the advisory committee to:

1. Periodically review the objectives of home health program.
2. Periodically review the criteria for patient eligibility.
3. Formulate or approve written agency policies and procedures with recommendations to the county board of health.
4. Promote use of the program by attending physicians on behalf of their private patients.
5. Inform the public of available home health services in order to stimulate their use when appropriate.
6. Relate to the public health nursing service team and administering agency (county board of health)

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CLARIFICATION

The State Department of Health section in the April issue of the JOURNAL OF THE IOWA MEDICAL SOCIETY contained a presentation entitled, "Regional Genetic Counseling in Iowa/A Status Report." The presentation was an original article submitted to the Department of Health for publication in the IMS JOURNAL. The authors of the article were Elizabeth J. Thompson, R.N., B.S.N., and James A. Bartley, M.D., Ph.D. Ms. Thompson is clinical coordinator of the Regional Genetic Consultation Service and Dr. Bartley is clinical director of the RGCS. The data presented was gathered by Ms. Thompson in 1980 with funding by University of Iowa Hospitals and Clinics.

STATE DEPARTMENT/ PUBLIC HEALTH

(Continued from page 305)

community acceptance, understanding of the programs and suggestions for improvement.

7. Provide technical and professional advice in areas such as patient care services, financing, administrative management and public relations.

8. Evaluate total agency (administration, programs, staffing) performance; develop recommendations based on results for presentation to board of health.

The community service given by local physicians throughout Iowa as active members of advisory committees has benefited many citizens through the increased volume and improved quality of public health nursing services delivered. A public thank you to the involved physicians and other committee members is in order.



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May 1981 Morbidity Report

Disease	May 1981 Total	1981 to Date	1980 to Date	Most May Cases Reported From These Counties
Amebiosis	0	2	3	
Brucellosis	0	0	4	
Chickenpox	1237	6527	6830	Scattered
Cytomegalovirus	2	10	10	Dubuque, Jefferson
Eaton's Agent infection	1	11	7	Johnson
Encephalitis, virol	3	7	6	Dubuque, Humboldt, Wopello
Erythema infectiosum	464	1069	387	Warren
Gastroenteritis (GIV)	1440	11968	12975	Scattered
Giardiasis	2	13	8	Dubuque, Monroe
Hepatitis, A	10	130	62	Pocahontas, Scott
Hepatitis, B	9	33	29	Linn, Polk
type unspecified	3	26	33	Delaware, Linn, Polk
Herpes Simplex	21	85	42	Johnson
Herpes Zoster	1	4	1	Block Hawk
Histoplasmosis	0	5	12	
Infectious mononucleosis	29	186	197	Linn
Influenza, lab confirmed	3	191	107	Polk
Influenza-like illness (URI)	3408	47251	47829	Scattered
Meningitis				
aseptic	5	24	10	Johnson
bacterial	20	68	54	Linn, Polk
meningococcal	4	16	5	Scattered
Mumps	4	38	33	Scattered
Pertussis	0	2	0	
Robies in animals	107	402	156	Crowford, Jefferson, Keokuk
Rheumatic fever	0	6	0	
Rubella				
(German measles)	3	3	3	Soc, Linn
Rubeola (measles)	0	1	20	
Salmonella	30	92	46	Dubuque, Scott, Sioux
Shigellosis	2	16	27	Davis, Wopello
Tuberculosis				
total ill	8	44	30	Chickosow, Polk
bact. pos.	4	26	23	Audubon, Linn, Polk, Scott
Venereal diseases:				
Gonorrhea	389	1849	1930	Polk, Block Hawk, Scott
Syphilis	4	12	8	Johnson

Laboratory Virus Diagnosis Without Specified Clinical Syndrome: Adenovirus — 1, Corroll, 1, Delaware, 2, Polk, 1, Scott; Guillain Barre Syndrome — 1, Appanoose, 1, Mohoska; Reye's Syndrome — 1, Soc, 1, Woodbury; Scarlet Fever — 2, Cerro Gordo, 1, Chickosow, 1, Des Moines, 1, Dubuque, 1, Emmet, 1, Linn; Blastomycosis — 1, Block Hawk, 1, Decatur, 1, Linn; Typhoid Fever — 1, Linn; Compylobacter — 1, Block Hawk, 10, Dubuque, 3, Johnson, 1, Marshall, 3, Polk, 1, Woodbury; Toxic Shock Syndrome — 1, Emmet, 1, Linn, 1, Polk, 1, Story.

ABOUT IOWA PHYSICIANS

Dr. Don C. Young, Des Moines, was guest speaker at the kick-off meeting of the Mahaska County Cancer Drive. . . . **Dr. Kirpal Singh**, staff psychiatrist at the Clarinda Mental Health Institute since 1973, resigned from MHI in April to become medical director for the Crossroads Mental Health Center in Creston and begin private practice of psychiatry in Clarinda. Dr. Singh received his medical education in India, studied psychiatry in England and took postgraduate work in St. Louis, Missouri prior to joining the Clarinda MHI staff. . . . **Dr. William C. Rosenfeld**, Mason City, was guest speaker at recent meeting of the Mason City chapter of the American Association of Medical Assistants. Dr. Rosenfeld spoke on his medical relief work in Cambodia. . . . **Dr. John F. Collins**, Davenport, has been appointed by Governor Robert Ray to the Iowa Emergency Medical Services Advisory Council. Dr. Collins will serve a 2-year term. . . . **Dr. Alfred J. Herlitzka**, Mason City, was guest speaker at the March meeting of the Wright County Medical Society. Dr. Herlitzka spoke on pulmonary diseases and treatment of lung cancer.

Dr. Dennis A. Weis and **Dr. Kirk D. Green** recently opened a family health clinic in Reinbeck. Dr. Weis and Dr. Green also practice family medicine in Grundy Center. . . . **Dr. James G. Lott** recently was named Clarion's "Boss of the Year." Dr. Lott is a past president of the Clarion Jaycees and a recipient of the Jaycee of the Year Award. He and Mrs. Lott recently received the "Friends of Education Award" from the Clarion Education Association. . . . **Dr. Alan D. Patterson**, assistant medical director of Powell Alcoholism Treatment Center at Iowa Methodist Medical Center in Des Moines, was guest speaker at recent

meeting of the Trinity Regional Hospital Auxiliary in Fort Dodge. Dr. Patterson spoke on drug abuse. . . . The new Bettendorf High School stadium recently was named Tou Velle Stadium to honor **Dr. Alwyn R. Tou Velle**, longtime Bettendorf physician. On March 30, Dr. Tou Velle was recognized by the Iowa High School Athletic Directors Association for his "outstanding contribution to Bettendorf High School and its athletic program." Dr. Tou Velle began his medical practice in Bettendorf in 1950. . . . **Dr. Loren A. Olson**, Ames, was guest speaker at a recent meeting of the Wright County Medical Society. Dr. Olson spoke on chemical dependency.

DEATHS

Dr. Frederick E. Marsh, 85, longtime Council Bluffs physician, died May 7. Dr. Marsh received the M.D. degree at Creighton University.

(Please turn to page 310)

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(Continued from page 309)

ty School of Medicine. He did extensive bacteriology research at Yale University and during World War I helped formulate the Schick test for diphtheria. Dr. Marsh was a former member of the Council Bluffs School Board; past chief of staff at Jennie Edmundson Hospital; and former head of the Council Bluffs Airport Commission. In 1972, he was named Volunteer of the Month by the Council Bluffs Volunteer Bureau. Among the survivors are two sons, **Dr. Frederick E. Marsh, Jr.**, and **Dr. Eugene L. Marsh**, both of Council Bluffs.

Dr. Sterling A. Barrett, 72, Waterloo, died May 21 at Allen Memorial Hospital. Dr. Barrett received the M.D. degree at Thomas Jefferson University Medical College in Philadelphia, Pa.; and completed his ophthalmology and otolaryngology residencies at Cincinnati General Hospital, Cincinnati, Ohio, and Henry Ford Hospital, Detroit, Michigan. He began his medical practice in Waterloo in 1938, retiring in 1972. Dr. Barrett was a member of the American Academy of Ophthalmology and Otolaryngology.

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THE IOWA MEDICAL FOUNDATION is no new kid on the block. It's existed since the early 1950's — *even if under different names*. The Foundation is an instrument of the medical profession that deserves notice. It is in the business of helping people.

The corporate purpose of the Foundation declares it shall engage in, assist, further, promote and contribute to the support of such charitable, educational and scientific activities and projects as are, in general, either directly or indirectly related to health or medicine.

This charge is a broad one. It gives the Foundation authority to go forward with a varied, humanity-serving program. And such has been the pattern of diversification in recent years.

What have been principal activities of the Foundation?

DR. GEORGE SCANLON MEDICAL STUDENT LOAN FUND

Historically, and mainly, the Foundation is in business to help Iowans aspiring to become physicians. Foundation money has been loaned to about 400 doctor-bound individuals. The total amount loaned to medical students over the past three decades is closing in on \$1 million.

The Foundation student loan fund honors the now-deceased Iowa City surgeon whose interest and persistence were responsible for the program's beginning. Dr. George Scanlon led the initial efforts to create the fund. Its original resources came through a 5-year assessment of Iowa physicians.

Since its early days the medical student loan fund has gained steadily in momentum. The decade of the 70's has been the most dramatic growth period. In those years \$394,252 was loaned to Iowans enrolled in medical schools. This pattern of support for medical education is continuing into the 80's; loans in the 1980-81 academic year were made to 31 students for a total of \$70,755.

Foundation loans are available up to \$3,000 per year. They are renewable. And the interest rate is a reasonable 9%. Recipients must be from Iowa, must be in good standing in school

and must demonstrate financial need.

In the 1980-81 academic year the 31 Foundation loan recipients came from 23 different Iowa communities. Also, 23 of these students were seniors, so a largely new crop of applicants will get the \$70,000 authorized for loans in the 1981-82 school year.

DR. HENRY ALBERT PHYSICIAN BENEVOLENCE AND PUBLIC HEALTH FUND

Dr. Albert practiced medicine in Iowa until his death many years ago. He stipulated that proceeds from his estate should be used for worthy purposes in the areas noted above. The Foundation has received nearly \$150,000 from this source since the mid-1960's.

For many years the Foundation has reported that financial aid is available from the Albert Fund to help needy physicians and/or their widows. In 1980, allied with this interest, the Iowa Medical Society initiated an Assistance Program for Troubled Physicians. The APTP serves voluntarily to help those Iowa practitioners whose lives have been beset by problems which need and deserve attention. The APTP and the Albert Fund have been tied together in a sense to provide manpower/expertise on the one hand and the necessary resources on the other. The combination has considerable potential for service.

OTHER PROJECTS

As stated, the Foundation is broadening its service. It is willing to receive requests for support — and has furnished help in some instances. It's helped sponsor the Hawkeye Science Fair for many years. It's been a benefactor to projects on adolescent problems, sports medicine, employment of the handicapped, etc.

NAME CHANGE

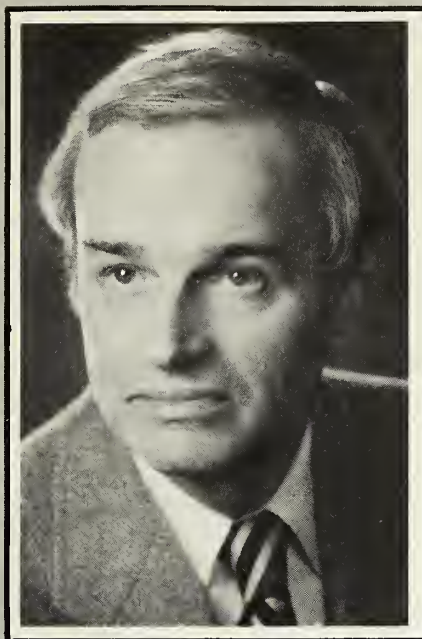
Because of this expanding involvement, the 11-member Foundation board of directors authorized a new name for the organization as of May 15, 1981. The change is from Scanlon Medical Foundation/Iowa Medical Society to Iowa Medical Foundation. Continued identification will be made under this new banner of the Scanlon and Albert Funds. And hopefully other such designated programs will emerge as time passes.

July 1981

Journal of the Iowa Medical Society



PRESIDENT'S PRIVILEGE



ADVOCATES OF SECOND OPINION programs for elective surgery have gained considerable attention in recent years. They theorize, of course, that too many physicians are performing too much surgery. They believe that light surgical workloads are being supplemented with unnecessary procedures. They contend there are too many physicians in surgical residency programs.

Various second opinion programs have been undertaken about the country intending to reduce the incidence of "inappropriate" surgery. The announced underlying goal is to curb rising health care costs. However, out of a conference sponsored by the Blues in New York last year has come the thought that while second opinion programs may have limited costs in themselves, they are not likely to produce savings in any broad sense.

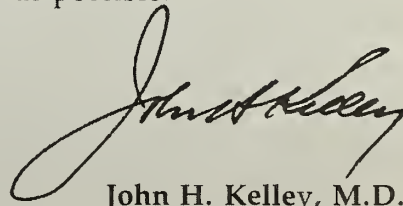
It was noted at this conference that of the second opinions obtained apparently 70% confirmed what the initial physician had recommended. Further, half of the remaining 30% received advice which was in substantial agreement with the first opinion.

Mandatory second opinion programs have been urged in some locations. Massachusetts has such a program. Published figures seem to show a significant savings. However, some question has been raised as to the authenticity of the figures developed to support this. In the year for which the figures were compiled

Medicaid fees were reduced by 30%, and apparently many physicians protested this reduction by not submitting bills. Furthermore, outpatient surgery and follow-up care were not counted.

Obviously, physicians should never discourage patients from seeking second opinions. We should help those who desire this back-up opinion. But making it a mandatory proposition is illogical. In the first place, there is no evidence that a second opinion is more valid than a first opinion. And while the administrative cost of such programs may not be excessive, the cost effectiveness overall is questionable — taking the time of a second physician and the investment this represents.

With only 2-4% of the eligible individuals taking advantage of such programs, the level of citizen interest is remarkably low. Why then add any mandatory requirement for these consultations? Where they are desired, by all means physicians should be supportive. However, where confidence and trust exist between physician and patient, then logic says this relationship should be nurtured as voluntarily and fully as possible.



John H. Kelley, M.D.

Adversity — Get Out of My Way!

J. E. O'DONNELL, M.D.
CLINTON, IOWA

IT IS GOOD for the medical profession to note the International Year of Disabled Persons through the JOURNAL OF THE IOWA MEDICAL SOCIETY. This worldwide observance is worthy of contemplation by Iowa physicians.

How can we focus in on the IYDP?

One way might be to recognize the person who is the current "Handicapped American of the Year." For he is a remarkable and unique citizen of Clinton, Iowa. He is the first Iowan to receive this award in its 30-year history.

When he was 19 Thomas "Pinky" McDonnell was my patient. That was in 1949. And he

had beginning poliomyelitis. His sister was already at University Hospitals with polio.

Now, some three decades hence, Pinky is still a good friend, a patient and a source of great inspiration. He developed full quadriplegia from a bulbar polio, spent many months in

Dr. O'Donnell and Mr. McDonnell are pictured on the cover of this issue of the IMS Journal.

an iron lung, and many, many more months in extended physiotherapy, not only at Iowa City, but in Warm Springs, Ga., etc.

Since then, from time to time, Pinky has been in precarious physical condition. He has had a resection of the colon and as recently as this April he had a coronary. But through all of the physical adversity Pinky emerged as a significant contributor to the life of his community and beyond.

While his need for constant care and his dependence on a motorized wheelchair, a special van, etc., are annoying facts of life, Pinky has not allowed himself to be shelved. He is well known as a member of the Clinton City Council. He has championed various causes to assist the elderly and handicapped. His humanitarian service goes beyond Clinton and Iowa. He's been a catalyst in the collection of books and educational materials for children overseas.

This comment by Lynn Schaley in the Clinton Herald tells the story of McDonnell succinctly: "Those who know and love McDonnell

Editor's Note — Dr. O'Donnell has practiced in Clinton since the early 1940's. He is a medical graduate of Northwestern University and had post-graduate training at Cook County Hospital in Chicago and at the Mayo Clinic. He comments here during the International Year of Disabled Persons about his friend and patient, Thomas "Pinky" McDonnell. In remembering the precarious circumstances facing the McDonnell family, Dr. O'Donnell remembers additionally his own early struggling days as a practitioner who was "happy to make house calls." He recalls that a donated collection of worn-out surgical instruments and the help of an absolutely magnificent wife ("my office nurse") were two crucial elements in a Clinton medical practice that still continues.

attribute his accomplishments to several different sources including his Irish ancestry, his basic optimism, his strong faith, the trials of two successful election campaigns and, most importantly, his love for people."

This ancestry reference is particularly vivid in my mind. When I think of the poverty and distress confronting this family in the 1940's and the tremendous courage it took to achieve so much, I am again and always filled with great admiration. There was no Medicare, no

Medicaid, no hospitalization coverage, no organized program to which this family could turn. And even so, one family member has become a Navy captain, one owns an organ company, and another operates a large insurance agency.

There is nothing more I think I need to say except that I know of no one that is more entitled to recognition than Pinky McDonnell, a marvel and an example of courage and goodness and the Grace of God.



COMMENTING EDITORIALLY

MARION E. ALBERTS, M.D.
SCIENTIFIC EDITOR

1981 — IYDP

THE INTERNATIONAL YEAR OF DISABLED PERSONS is being observed throughout the world in 1981. This observance was conceived in 1976 when a delegation from Libya introduced a resolution in the United Nations General Assembly. In 1977 the U.N. General Assembly approved a draft plan for the Year and established an IYDP advisory committee.

A report was submitted to the Secretary General in 1979 recommending that all member nations be invited to adopt measures to achieve the objectives of IYDP. *Full Participation* was accepted as the theme for the Year. An official logo was adopted showing two persons in a position of equality with hands held to demonstrate solidarity and support for each other.

The United States has had an active role in supporting international efforts to meet the needs of hundreds of millions of disabled persons. In addition to co-sponsoring the resolution that proclaimed 1981 as International Year

of Disabled Persons, the U.S. has supported the principles of the Universal Declaration of Human Rights, the Declaration on the Rights of Mentally Retarded Persons and the Declaration on the Rights of Disabled Persons. The IYDP theme will strengthen these convictions.

Recently we have been thrilled by the accomplishments of the blind daughter of one of our physician colleagues. Imagine the excitement that filled the heart of Sheila Holzworth as she climbed to the peak of Mt. Ranier. Her handicap has been supplanted with a determination possessed by few of us who have our sight, hearing and motor ability.

This issue of the JOURNAL acknowledges the International Year of the Disabled Person. The

For more about IYDP see this month's Questions/Answers discussion by William de Gravelles, M.D., on page 325.

medical profession needs to take an even stronger position in seeking an end to discrimination and demeaning practices against handicapped persons. The potential possessed by individuals with physical and/or mental handicaps is an untapped resource. They must be helped to live independently and to enjoy the fullest possible participation in community life.

Physicians are in a unique position to help disabled Americans achieve mainstream status. We need to demonstrate to our brethren at home and in other countries we have the dedication and intent to carry forward the principles of the IYDP into succeeding years. — M.E.A.

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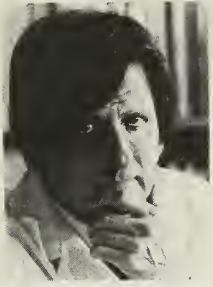
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QUESTIONS - ANSWERS

WILLIAM DEGRAVELLES, M.D.
Des Moines, Iowa

INTERNATIONAL YEAR OF DISABLED PERSONS

Dr. deGravelles has been medical director and chief of physical medicine at the Younker Memorial Rehabilitation Center of Iowa Methodist Medical Center since it opened in 1959. He was named last year as Physician of the Year by the President's Committee on Employment of the Handicapped. He comments here in observance of 1981 as the International Year of Disabled Persons.

As this is the International Year of Disabled Persons, we would ask you what is the greatest need facing the disabled Iowan today?

I believe disabled persons would say their greatest need is an equal opportunity. In broad terms this includes available transportation, housing, accessibility of work site and public recreation, social acceptance and adequate income. While these many accommodations may sound imposing, they provide changes in the environment that offer the disabled person the same opportunity as the able bodied individual.

Have strides been made to assist disabled persons since you began medical practice? Could you note one or two areas of progress?

Tremendous strides have indeed been made, both in medical care and in society as a whole over the past 25 years. Medical care for the person with either a congenital disability or

one resulting from illness or injury has advanced along with all aspects of U.S. health care. Many more persons survive acute stages of illness or injury; the rehabilitation resources have grown similarly. Physicians and paraprofessionals specializing in physical medicine and rehabilitation are better trained and increasing in numbers. Services are now available to most people within a reasonable geographic area. Twenty-five years ago you had to travel long distances to be treated in one of 8 or 9 rehabilitation centers.

Locally, and at the state level, through the Governor's Committee on Employment of the Handicapped, services and resources are available. What basic information do Iowa physicians need to have to properly refer their handicapped patients for assistance?

I strongly support the Governor's Committee, as well as other agencies in and out of government which offer well organized services. Of special note is the Easter Seal Society and its Camp Sunnyside. This camp is one of the finest in the country. The State Services of Vocational Rehabilitation is another agency serving the handicapped. Iowa physicians should be aware of the services offered by these many different groups. They can be contacted for information and my experience is that they are always ready to help.

The availability of technology, specialized equipment, etc., continues to increase. Is there any good way for physicians to stay up to date on this kind of development?

Advances continue in technology, including prosthetics and orthotics, self-help equipment, electronic devices and mobility aids. There is major research at a number of universities. It is difficult for physicians to stay on top of this kind of development unless they are actively involved in a rehabilitation effort of some kind. Changes occur often enough so the only practical means of keeping abreast is to contact specialists in rehabilitation who are associated with hospitals or agencies providing comprehensive services. People in rehabilitation are always willing to share their expertise and information.

(Please turn to page 339)

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THINGS YOU SHOULD KNOW

HIGH RANKING

The medical profession ranks third behind God and President Reagan in level of trust, according to findings of the Iowa Poll which were reported in the July 5 Des Moines Sunday Register. The profession moved from fourth in a 1977 survey to third in the most recent poll.

GARRED NAMED TO BME

John L. Garred, M.D., was named in July to succeed C.L. Beye, M.D., Sioux City, on the State Board of Medical Examiners. Dr. Garred is a family practitioner in Whiting. He has been active in the IMS including service on the Legislative Committee; he's also on the board of the Iowa Medical Political Action Committee.

HMO FOR DUBUQUE

Medical Associates of Dubuque has announced plans to establish a health maintenance organization in that community. It will be a closed-panel type of HMO available to all Dubuque employer groups. Operational status will be sought as rapidly as possible.

PRINTING SERVICE

Low cost assistance is now available to IMS member physicians in meeting printing needs. The Society has obtained a new floor-model offset press and is equipped to provide stationery, envelopes, forms, Rx pads, etc., to interested offices and clinics. Please contact IMS headquarters for more info.

BOARD OF HEALTH

At its July meeting, the State Board of Health re-elected Paul Seebohm, M.D., Iowa City, and Aaron Randolph, M.D., Anamosa, as president and vice-president, respectively. Three new Board members are Marshalltown pharmacist Mary Ellis; Karla Lowe-Phelps, R.N., Waterloo, and Colleen Shaw, Corning, a registered dietitian.

DISCLOSURE PROTECTION

An emergency rule was approved in July by the State Board of Health to restrict public access to certain information (some medical in nature) on birth, death, marriage and divorce records. The rule seeks to mollify legislation passed recently. A permanent version of the emergency rule is to be reviewed at an August 17 hearing.

CARDIOVASCULAR SERVICES

The required appropriateness review of specialized cardiovascular services appears likely to reach culmination in September. The findings and recommendations have been reviewed by IMS representatives coincident with their adoption by the IHSA and the Illowa HSA. Adoption of the material is expected by the Statewide Health Coordinating Council in September.

NEW NAME OFFICIAL

News reports in July indicated the name of the College of Osteopathic Medicine and Surgery has been changed to University of Osteopathic Medicine and Health Sciences. This new name coincides with the admission of the first class of 11 physician assistant students. A podiatry school has been announced to open in 1982.

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VOX DOCS

Please take a look at this month's Vox Docs question below. Then give us your answer. Send it to IMS JOURNAL, 1001 Grand Avenue, West Des Moines, Iowa 50265. Last month's question/answer results are shown to the right with several comments received.

"Solo practice will decline in larger cities but will survive in smaller communities due to the desire to be independent." — M. G. Sloan, M.D., Boone

"I have enjoyed solo practice for 20 years, but I'm now enjoying a partner. Solo practice is very demanding medically, and the increasing flood of paper work makes it nearly impossible." — V. L. Moldenhauer, M.D., Marengo

"Overproduction of physicians and oversupply will close many groups and force a significant number to be in solo practice." — S. R. Helmers, M.D., Sibley

"Many physicians are only comfortable (and therefore only successful) in a solo practice setting." — K. A. Garber, M.D., Corydon

LAST MONTH'S QUESTION —

Is solo practice doomed to extinction before the end of the century?

YES, IT WILL BE A RARITY 20%

NO, IT'LL SURVIVE IN SOME REASONABLE AMOUNT 80%

"There are individuals who prefer to work alone for whatever their reasons. There are practice factors, including the size of a community, that do not lend themselves to group practice." — J. W. Olds, M.D., Des Moines

"I think Dr. W. B. Bean said that group practice was of most benefit to the doctors, not patients, which explains the popularity. As groups fill up and patients become scarce, young doctors, like lawyers and dentists, will be forced to 'hang out their shingles' once again. Each young doctor should, once, start and manage his or her own practice as an educational experience. 'Coverage' is overrated as a reason for groups; competitors can cover. If you can't trust a man as a competitor you sure can't trust him as a partner." — Anonymous

AUGUST QUESTION FOR IOWA PHYSICIANS

Physical examinations are required annually for participation in school athletics. Is this annual requirement okay or could it be made less frequent?

- ☐ NECESSARY ON AN ANNUAL BASIS
- ☐ COULD BE EVERY OTHER YEAR
- ☐ COULD BE EVERY THIRD YEAR, SAY SEVENTH GRADE AND TENTH GRADE

Comment, please _____

Name _____

Address _____

(Please Complete and Send to IMS JOURNAL, 1001 Grand Avenue, West Des Moines, Iowa 50265)



**They aren't thinking
about medical necessity.**
(Because their physician did.)

In addition to the significant cost savings associated with ambulatory surgery programs, same-day surgery reduces apprehension for patients facing hospitalization.

Blue Cross and Blue Shield of Iowa support outpatient programs when medically appropriate as a means to reduce the cost of health care in our state, and at the same time provide the benefits of recovery and recuperation in the home with less time away from family and work.

The Iowa Foundation for Medical Care (IFMC), with input from the Iowa Medical Society and Blue Cross and Blue Shield of Iowa, have developed a list of surgical procedures that can be safely performed in an outpatient setting.

We encourage physicians to familiarize themselves and their patients with the IFMC's list and seek outpatient arrangements whenever medically appropriate.



Recognizing and Managing The Psychosomatic Patient

B. FRANK VOGEL, M.D.

Cherokee, Iowa

HENRY MAUDSLEY, a renowned neurologist in the late 1800's, once said, "The sorrow which has no vent in tears may make other organs weep."

The illnesses represented here are called psychosomatic disorders or psychophysiological autonomic and visceral disorders. They have existed as long as man. The effects of anxiety, fear, and anger have their derivatives in guilt and shame. When aroused they sometimes are strong enough to break through the psychological defenses we employ routinely and unconsciously. Such emotions proceed to disturbances that are expressed predominantly through physiological processes.

Neither the neuroses, nor conversion symptomatology, nor the somatoform disorders have demonstrable organic findings to explain their symptoms. The psychosomatic disorders

Every physician now-a-days is encountering the psychosomatic patient in increasing numbers in his practice. It is the author's contention that the family practitioner should be the treating physician in such cases. Rarely will such patients require referral to psychiatric colleagues. Some essential diagnostic criteria and treatment suggestions are outlined.

do have such findings, because of the stress of long-continued and exaggerated physiological expressions of emotions. These result in dysfunctional and eventual structural changes, which take place either in the organ or viscus through which they are expressed. These changes are secondary to vascular disturbance, to smooth muscle dysfunction and to hypersecretion or hyposecretion of glands, which are innervated mainly by the sympathetic and parasympathetic divisions of the autonomic nervous system. Psychosomatic medicine concentrates on the role of psychosocial variables, not in causing disease but in altering individual susceptibility to it. It may be defined as the study of the reciprocal relationships among

Dr. Vogel is Director of Clinical Services at the Mental Health Institute, Cherokee, Iowa.

THE IOWA MEDICAL FOUNDATION HAS DESIGNATED THIS ARTICLE AS THE HENRY ALBERT
SCIENTIFIC PRESENTATION FOR THE MONTH OF AUGUST 1981

sociological, psychological and biological factors influencing the individual.

The influence of psychoanalysis has waned in recent years. This is so because it has been difficult to validate the assumed importance of specific unconscious psychological factors in the pathogenesis of psychosomatic disorders. However, psychoanalytic concepts and methods of observation continue to be of use as they contribute knowledge of the unconscious significance for the person, of the symbolic meaning of body parts and functions, and of unconscious motivation and conflicts. These factors influence psychophysiological responses: the life events, situations, susceptibility and psychological reactions to illness. Nevertheless, unconscious factors are merely one class of relevant variables that must be studied in relation to all of the other classes, to achieve comprehensive knowledge and to understand the actual genesis of a psychosomatic disorder.

RECOGNITION OF PSYCHOSOMATIC PATIENT

This is a difficult task; however, here are certain essentials:

1. *Symptoms may involve one or more organ systems.*
2. *Subjective complaints exceed objective findings.*
3. *A temporal coming together of symptom development and psychosocial stresses.*
4. *A combination, that appears long-lasting, of biogenetic and developmental patterns.*
5. *A failure of usually successful therapeutic modalities, tried sometimes in unending sequence.*

A careful history taken by the physician is preferred over one taken by a secretary, or even the patient writing uninformative answers to stereotyped questions. True, the history-taking needs to be formalized and directive but the patient should be permitted an amount of free play to speak in random fashion about his health. Many clues can be picked up and followed in future sessions.

One should be alert to all emotional components of physical illness. Among these, the attitude toward illness will be first to surface. Here one may discern motives that delay recovery. Another component concerns factors arising from the social environment or that

come from interactions between the patient and his social setting. A further component is the psychological need of the patient. There are negative and positive needs.

We are all acquainted with the fears of mutilation, of loss of vital structure or of a capacity that threatens a patient's sense of security. We should also think of what, to the patient, are positive aspects of an illness. There are certain luxuries, certain satisfactions of emotional needs, such as the warmth of feeling and interest manifested by family members, by neighbors, friends, and the nursing personnel. So, at times, it is difficult for a patient to give up his illness. We need to consider personality patterns and may find that certain characteristics are of greater importance in producing or maintaining the individual's illness than apparent etiological agents.

Lastly, one component brought into light recently has to do with the patient's influence on his family, and reciprocally, the influence of the family on the patient. This can become a reverberating circuit by negative feedback. The patient's irritability, his complaints, and his prolonged disability react on the family and impair the mental health of family members or the family as a unit. If any member of the family or the family as a whole react negatively towards the patient, this will set up a vicious cycle which will reinforce the illness and motivate the patient towards more doctor shopping.

The comprehensive history should cover as much as possible of the development and experiences of the patient. The jealousies, frustrations of home or of working conditions which often involve boredom, or a striving for security or achievement, with rivalry, can be common and continuing stressful problems. Interpersonal relationships: a marriage, an engagement or a friendship can all produce tensions and anxieties, and consequently impair physiological functioning. A lack of emotional satisfaction often produces a psychosomatic disorder. Anxiety reactions to situational difficulties and crises can be expressed in psychosomatic symptoms. There should be definite inquiry about events that occurred before the onset of the illness and information secured about personal situations that may have given rise to anxiety, to hostility, to aggression, to guilt, to bottled-up resentment and to other disturbing emotions.

A relationship often can be established between the physical symptoms and the emotion disturbing event. Less often, it is possible to identify experiences of early life that influenced adult attitudes and ultimately disease. Observations have been made that psychosomatic disorders may be organ reflections of psychological tension. These are more common in the middle class because of the work ethic. The individual himself picks the goal of striving, of conforming, and of repressing socially unaccepted attitudes and emotions. There is a greater tendency for emotionally introverted persons to show somatic complaints than for those who are extroverted. Physical symptoms are the presenting ones and dominate the clinical picture. The patient, himself, may not complain of anxiety, of depression, of resentment, or of sexual discontent, but rather of a disorder of bodily functions, such as anorexia, vomiting, backache, headache, palpitations and the like.

MANAGEMENT OF THE PSYCHOSOMATIC PATIENT

A judicious selection must be made of people who may be amenable to brief therapy. Certainly one selection criteria could be people who have not had psychotherapy, in any form, before. There should be no indication of any chronic mental illness, such as a long-lasting depression or some personality disorder that has been overlaid by a recent and superficial somatic disorder. The individual should be of good intelligence and cooperative enough to come for a dozen sessions or so, where not much will be done except to talk. Usually this is acceptable because everyone likes to be in the limelight. To be the focus of someone's complete and positive attention is something the patient may not have had for many years.

There should be medical support given by the primary physician. The best individual to treat the patient with a psychosomatic disorder is the family practitioner who is the first person to whom the patient comes. If and when necessary, consultations can be asked for, but the treatment should remain in the hands of the practitioner. Most family practitioners certainly are capable of establishing a working therapeutic doctor-patient relationship. This is the mainstay of treatment. The first and major factor to remember and to use, is that the physician accepts the patient's distress as real. An

extremely complete initial physical examination should be done. Then efforts should be made to relate the patient's symptoms to unusual or stressful developments in recent life. Have the patient keep notes and put down whatever occurs to him as pertinent in the genesis of his particular illness. Appointments should be regular, at least weekly, and short. Prescriptions should not be written simply to space the appointments. The attitude of the physician should be realistic, and definite, but not grandiosely or omnisciently optimistic. Patients will look askance at the physician who promises too much, especially if they have already been through a prolonged period of changing physicians and know their illness has fluctuated. Sedatives should not be used and minor tranquilizers should be used sparingly; the prescription should not be refilled. If tensions and anxieties are extremely marked and interfering; only then should medication be prescribed.

The behavioral approach is a recent one that has been effective in some psychosomatic disorders. It is best exemplified by current biofeedback techniques. There are certain criteria for the use of these techniques and not every physician will feel he has the time, the interest, or the equipment for this approach. With immediate feedback to the patient, who can recognize and monitor his high blood pressure or his increased peristalsis or the like, he can learn to identify any change he might evoke and thus become a conscious originator and participant in the therapy, and not just a passive recipient. Relief of the symptom will help the patient use the particular maneuver he has learned. For example, he finds if he deliberately and consciously helps himself relax, by listening to a relaxation tape, then a decrease in bowel sounds or a diminution of his migraine ensues. With emphasis on this type of learning, the patient early identifies symptoms and appreciates the counter-manuevers, and thus diminishes his particular problem.

Social endeavors are rather widespread and may not be feasible in every instance. These include family, the work situation, and other interpersonal activities. Sometimes family members come for a number of sessions to learn how they can live best with a particular

(Please turn to page 334)



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patient. There are clubs, such as ostomy clubs, which provide a climate for encouraging patients to accept and live with certain disabilities. Sometimes communication with the patient's employer is necessary to help the patient with his work difficulties. The school, similarly at times, must be contacted and its patience must be enlisted.

USE OF PRIMARY PHYSICIAN

The psychological approach to treatment can and certainly should be used by the primary physician. This is often best developed on a here-and-now basis and oriented towards actual changes rather than the insight or genetic type of treatment. Sometimes, group therapy with patients who have similar problems can be of value, to allow greater understanding of other people's problems, to permit ventila-

tion, and to focus on getting along with other people.

The best type of psychological therapy is brief psychotherapy. The physician will set a time limit for the treatment. This is not a hard and fast decision. It can be extended if not enough progress has been made. One should not be overly optimistic about the shortness of therapy, but it is appropriate to plan a three month period of one or two sessions per week. The physician should have a reasonably optimistic attitude to project to his patient. Following the first sessions, there may be so much beneficial effect that the physician and the patient will become overconfident and presume the treatment will be over shortly. This is fallacious, and is ascribed to the rise of high transference feelings, sometimes called "the honeymoon transference." The expectations are unreasonable since an illness of months or years will not be amenable to one or two weeks of treatment. The middle sessions are the difficult ones. At this time, the patient, by intelligent and continued physician-assisted correlations with incidents in his past life and the reaction to them brings together important material. The patient prefers not to understand or accept such correlations because to do so would be to experience the discomfort or pain he has successfully avoided by substituting symptoms or a physical illness. This is the difficult part of therapy. It can be helped by a good relationship, by a careful physical examination, by taking an extensive history, by showing interest and concern. Interpretations are rarely given and some physicians never do so. They continue their work with the correlations to bring together apparent disparate incidents and emotional reactions.

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Legionnaires' Disease Among Pneumonias in Iowa (FY 1972-1978)

CHARLES M. HELMS, M.D., Ph.D.

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LEGIONNAIRES' DISEASE was first recognized in association with an explosive outbreak of pneumonia that occurred at the Bellevue-Stratford Hotel in Philadelphia, Pennsylvania in July 1976.¹ Isolation of the presumptive etiologic agent, a fastidious, aerobic Gram-negative bacterium was reported 6 months after the epidemic.²⁻⁴ This previously unrecognized microorganism appears to represent a new bacterial species and has been designated *Legionella pneumophila*.⁵

The frequency with which *L. pneumophila* infections occur in the community is not known with certainty. In this report we present information obtained from 799 cases of pneumonia occurring over the 7-year period of July 1971 through June 1978.

The authors are associated with the University Hygienic Laboratory, the Department of Internal Medicine, University of Iowa Hospitals and Clinics, and the Department of Microbiology, The University of Iowa, Iowa City, Iowa 52242.

Sera from 799 pneumonia cases were studied to determine the frequency of Legionnaires' disease (*Legionella pneumophila* infections). Recent *L. pneumophila* infections were associated with 3.8 to 8.1% of these cases. *L. pneumophila* infections were 2.3 times as common in men as in women, and the majority of infections occurred in individuals ≥ 40 years of age. In 40-59 year old men the frequency was 13%, equal to the combined frequencies of *M. pneumoniae* and influenza A virus infections. Most *L. pneumophila* pneumonias occurred between June and November. In July, about 1 pneumonia in 6 was caused by *L. pneumophila*. *L. pneumophila* infections were as common as *M. pneumoniae* infections in June, July, and August. The authors conclude Legionnaires' disease is not uncommon and should be highly suspect in pneumonias occurring between June and November in males 40 years of age and older.

MATERIALS AND METHODS

Sera from pneumonia cases. Since 1965, paired sera from patients with respiratory infection submitted for diagnostic serology have been systematically collected and stored at the University Hygienic Laboratory, Iowa's state diagnostic laboratory. Sera have been preserved at -65°C in tightly sealed screwcapped vials. Acute and convalescent sera submitted during fiscal years (FY) 1972 through 1978 from all patients with clinical diagnoses of pneumonia were selected for this study. These selected sera (799 serum pairs) comprised 3.8% of all

TABLE 1
FREQUENCY OF *L. PNEUMOPHILA* INFECTIONS AMONG
PNEUMONIA CASES IN IOWA (FY 1972-1978)

Year(s)	Number of Pneumonias	Infections Indeterminate		Total
		Recent	Onset	
1972	57	2	17	19
1973	90	1	26	27
1974	112	3	10	13
1975	111	4	3	7
1976	120	9	7	16
1977	96	5	4	9
1978	213	6	23	29
1972-1978	799	30 (3.8%)	90 (11.3%)	120 (15.0%)

sera submitted to the University Hygienic Laboratory during the 7-year period. Only 3 diagnoses of Legionnaires' disease in association with a primary diagnosis of pneumonia were found. These diagnoses were submitted in FY 1978 when statewide educational efforts regarding Legionnaires' disease began.

Serology. All serum pairs were examined for antibodies to *L. pneumophila* (Philadelphia 1 isolate) by the indirect fluorescent antibody (IFA) technique employing ether-killed organisms.⁴ Reagents for this test were generously provided by the Center for Disease Control, Atlanta, Georgia. Standard complement-fixation (CF) tests for antibodies to influenza A and influenza B viruses, *M. pneumoniae*, and adenovirus⁶ had been performed on 663 (82.9%) of the 799 pairs at the time of submission.

Definitions. A pneumonia case in which a four-fold or greater rise in IFA titer to $\geq 1:128$ occurred between acute and convalescent sera was defined as a recent infection with *L. pneumophila*. In epidemics of Legionnaires' disease, nonrising IFA titers of $\geq 1:128$ or $\geq 1:256$ have also proven useful in identifying recent *L. pneumophila* infection.⁴ The accuracy of this serologic convention in identifying recent *L. pneumophila* infections among sporadic cases of Legionnaires' disease is not known, however. For this reason, a pneumonia case in which no significant titer rise occurred, but in which one of the paired sera had an IFA titer of $\geq 1:256$, was defined as an *L. pneumophila* infection of indeterminate onset.

A recent influenza A virus, influenza B

virus, adenoviral or mycoplasmal infection was defined as a case in which a four-fold or greater rise in specific CF antibody titer occurred.

RESULTS

Frequency of *L. pneumophila* infections. Recent *L. pneumophila* infections occurred in association with 30 (3.8%) of the 799 pneumonias examined (Table 1). The yearly frequency of recent infection did not vary widely and ranged from 1.1% (1 of 90 pneumonias) in FY 1973 to 7.5% (9 of 120 pneumonias) in FY 1976. *L. pneumophila* serology indicating infections of indeterminate onset occurred in association with 90 (11.3%) of the pneumonias. In contrast to recent infections, the yearly frequency of infections of indeterminate onset ranged widely from 2.7% (3 of 111 pneumonias) in FY 1975 to 29.8% (17 of 57 pneumonias) in FY 1972. The reasons for such variability are not clear. The possible role of serum dehydration in causing such variability has been examined and excluded.⁷ Differences in median age and sex composition of pneumonia cases in each year have been examined and do not satisfactorily account for the observed variability.

Assuming that all infections of indeterminate onset were recent infections, the crude range of frequency of *L. pneumophila* infections among all pneumonias studied was 3.8 to 15.0%. An estimate of the upper limit of the frequency of recent *L. pneumophila* infection was obtained indirectly. Three control populations in which the detection of an IFA titer $\geq 1:256$ would most likely indicate past infection were studied. Among 289 sera from healthy individuals, hospitalized patients and patients with respiratory infections known to be caused by pathogens other than *L. pneumophila*, the frequency of an IFA titer $\geq 1:256$ was 6.9%. By subtracting this figure from the crude 15% overall infection rate, a more accurate estimate of the maximal frequency of recent *L. pneumophila* infections of 8.1% is obtained.

Relative frequencies of infections with *L. pneumophila* and other respiratory pathogens. To put the frequency of *L. pneumophila* infections in some perspective, the frequencies of recent *M. pneumoniae*, influenza A virus, influenza B virus, and adenovirus infections among the pneumonias were determined. Of 663 pneumonia cases in which serologic tests for infection with 5 agents had been performed,

only 168 (25.3%) were accompanied by evidence of infection. *M. pneumoniae* infections were most frequently detected (13.9%), followed by influenza A virus infections (6.3%). *L. pneumophila* infections were next in frequency (3.9%) followed by influenza B virus and adenovirus infections (1.2%). Thus, *L. pneumophila* was the third most prevalent pathogen identified in this group of pneumonias.

Sex and age frequencies of L. pneumophila infections. Recent *L. pneumophila* infections were 2.3 times as common in men (21 cases) as in women (9 cases) (Table II). Excepting those less than 1 year of age, infections were detected in all age groups. Sixty-three percent of all infections (19 of 30) occurred in individuals 40 years of age and older, however. In men ages 40 to 59 years 12.7% of pneumonias were caused by *L. pneumophila*.

Relative frequencies of infections with L. pneumophila and other respiratory pathogens by age. The age frequencies of recent *L. pneumophila*, *M. pneumoniae*, and influenza A virus infections among the pneumonias are shown in Table III. As expected, *M. pneumoniae* infections were most common in pneumonias in individuals less than 40 years of age. Influenza A virus infections were most frequent in pneumonias in those 60 years of age and older. Interestingly, among pneumonias in individuals 40 to 59 years old, *L. pneumophila*, *M. pneumoniae*, and influenza A virus infections were detected with almost equal frequency.

The relative sex frequencies of *L. pneumophila*, *M. pneumoniae*, and influenza A virus infections among pneumonias in the 40-59 year old

TABLE II
FREQUENCY OF RECENT *L. PNEUMOPHILA* INFECTIONS AMONG
PNEUMONIA CASES IN IOWA BY SEX AND AGE (FY 1972-1978)

Age in Years	Fraction (%) of Pneumonias in Each Age Group Associated with <i>L. pneumophila</i> Infection		
	Males	Females	Both Sexes
< 1	0/16 —	0/8 —	0/24 (0.0%)
1-19	1/121 (0.8%)	3/90 (3.3%)	4/211 (1.9%)
20-39	4/111 (3.6%)	3/110 (2.7%)	7/221 (3.2%)
40-59	10/79 (12.7%)	3/84 (3.6%)	13/163 (8.0%)
≥ 60	6/63 (9.5%)	0/61 (0.0%)	6/124 (4.8%)
Unknown	0/26 (0.0%)	0/30 (0.0%)	0/56 (0.0%)
All ages	21/416 (5.1%)	9/383 (2.4%)	30/799 (3.8%)

age group are instructive. In men *L. pneumophila* infections accompanied 14.3%, influenza A virus infections 7.9%, and *M. pneumoniae* infections 4.8% of pneumonias. Among women this rank order of frequency of infection was reversed.

Seasonal variation in the frequencies of infections with L. pneumophila and other respiratory pathogens. The frequencies with which recent *L. pneumophila*, *M. pneumoniae*, influenza virus, and adenovirus infections occurred among pneumonia cases varied strikingly by month (Table IV). *L. pneumophila* infections were most prevalent in the summer and fall, 81% (21 of 26 infections) occurring between the months of June and November. *M. pneumoniae* infections showed a similar seasonal distribution, 79% (73 of 92 infections) occurring between June and December. In contrast, nearly all influenza A

(Please turn to page 338)

TABLE III
RELATIVE FREQUENCIES OF RECENT INFECTIONS WITH *L. PNEUMOPHILA*, *M. PNEUMONIAE* AND INFLUENZA A VIRUS AMONG
PNEUMONIA CASES IN IOWA BY AGE (FY 1972-1978)

Age in Years	No. of Pneumonias	Number (%) of Pneumonias in Each Age Group Associated With Infection With Indicated Agent(s)			
		<i>L. pneumophila</i>	<i>M. pneumoniae</i>	Influenza A Virus	All Agents
< 1	18	0	1 (5.6%)	0	1 (5.6%)
1-19	177	2 (1.1%)	36 (20.3%)	6 (3.4%)	44 (24.9%)
20-39	189	5 (2.7%)	37 (19.6%)	9 (4.8%)	51 (27.0%)
40-59	140	12 (8.6%)	10 (7.1%)	10 (7.1%)	32 (22.9%)
≥ 60	113	5 (4.4%)	6 (5.3%)	17 (15.0%)	28 (24.8%)
Unknown	2	0	0	0	0
All ages	639	24 (3.8%)	90 (14.1%)	42 (6.6%)	156 (24.4%)

TABLE IV
RELATIVE MONTHLY FREQUENCIES OF RECENT INFECTIONS WITH *L. PNEUMOPHILA*, *M. PNEUMONIAE*, INFLUENZA A VIRUS, INFLUENZA B VIRUS, AND ADENOVIRUS AMONG PNEUMONIA CASES IN IOWA (FY 1972-1978)

Month	No. of Pneumonias	Number (%) of Pneumonias in Each Month Associated With Infection With Indicated Agent(s)				
		<i>L. pneumophila</i>	<i>M. pneumoniae</i>	Influenza A Virus	Influenza B Virus and Adenovirus	All Agents
January	86	3 (3.5%)	6 (7.0%)	23 (26.7%)	1 (1.2%)	33 (38.4%)
February	59	0	2 (3.3%)	3 (5.1%)	3 (5.1%)	8 (13.6%)
March	41	0	1 (2.4%)	3 (7.1%)	2 (4.8%)	6 (14.6%)
April	46	1 (2.2%)	5 (10.9%)	1 (2.2%)	1 (2.2%)	8 (17.4%)
May	46	1 (2.2%)	5 (10.9%)	0	0	6 (13.0%)
June	24	2 (8.3%)	1 (4.2%)	0	0	3 (12.5%)
July	39	7 (18.0%)	7 (18.0%)	0	1 (2.6%)	15 (38.5%)
August	42	4 (9.5%)	5 (11.9%)	0	0	9 (21.4%)
September	69	4 (5.8%)	7 (10.1%)	1 (1.5%)	0	12 (17.4%)
October	55	3 (5.5%)	16 (29.1%)	0	0	19 (34.6%)
November	73	1 (1.4%)	23 (31.5%)	1 (1.4%)	0	25 (34.3%)
December	83	0	14 (16.9%)	10 (12.1%)	0	24 (28.9%)
All months	663	26 (3.9%)	92 (13.9%)	42 (6.3%)	8 (1.2%)	168 (25.3%)

virus, influenza B virus, and adenovirus infections were clustered in the winter and spring months of December through April.

L. pneumophila infections were most frequent in July, when 18% of pneumonias were associated with recent infection. Among pneumonias occurring in the months of June, July, and August, *L. pneumophila* infections were as common as *M. pneumoniae* infections.

DISCUSSION

It has been estimated previously that 1-4% of atypical pneumonias occurring in the United States may be due to *L. pneumophila* infection.^{4, 7, 8} Present results confirm these estimates and suggest that *L. pneumophila* pneumonias probably account for no less than 3.8% and no more than 8.1% of atypical pneumonias in Iowa.

The frequency of *L. pneumophila* infections was clearly elevated in several select subpopulations: in men and in individuals 40 years of age and older. Indeed, the frequency of *L. pneumophila* pneumonias in men 40 to 59 years of age may have been as high as 14% of all pneumonias.

While among the pneumonias studied, *L. pneumophila* infections occurred less frequently than *M. pneumoniae* and influenza A virus infections, the relative rank order of these 3 pathogens was variable depending upon the sex and age of the pneumonia patient and the

season of occurrence. *L. pneumophila* was by far the most prevalent of the 3 pathogens causing pneumonia among men 40 to 59 years of age. In addition, *L. pneumophila* infections were the first or second-ranking cause of pneumonia from June to October. Indeed, *M. pneumoniae* and *L. pneumophila* infections appear to have occurred with equal frequency during those months.

Only 25% of the pneumonias studied could be associated with *L. pneumophila*, *M. pneumoniae*, influenza A virus, influenza B virus, and adenovirus infections by serologic methods. How many more infections might have been detected had cultural attempts to isolate respiratory pathogens been possible is unknown. The relative rank order of infections with these agents may be altered, therefore, by studies employing cultural techniques. Whatever the ambiguity introduced by results obtained by serologic methods alone, it appears that *L. pneumophila* is not an infrequent pathogen among pneumonias in the state of Iowa. Further research to outline the magnitude of the problem of *L. pneumophila* infection is necessary to guide responsible agencies in establishing priorities and developing programs in public health and medical research on Legionnaires' disease.

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QUESTIONS/ANSWERS

(Continued from page 325)

Is there a personal philosophy you might share with Iowa physicians as to how you treat handicapped patients?

My philosophy is influenced by my own personal situation in that I was a recipient of rehabilitation services as a young adult. One has to deal gently but consistently with the reality situation . . . a person's lifestyle may be drastically altered but it is not over. Realistic goals must be set and then one "must get on with it." I cannot overemphasize the need for continued support from family and friends. The newly disabled person desperately needs this support. It is often the determining factor in one's

ability to cope with the many problems and to be motivated to give the 100% effort needed to reach one's highest potential of function.

Has the awareness of the general public increased in the past decade with respect to employment of disabled Americans?

Yes. I believe this is due largely to contributions made by the handicapped people themselves who are working and who are contributing members of society. Not only are they employed, but many are members of local, state and national boards and committees. They are in the community, visible, making viable and outstanding contributions to society in general. The job is not done. There continue to be areas of discrimination but they are slowly being replaced by accomplishments of dedicated individuals, able bodied as well as the disabled.

MEDICAL ASSISTANTS SESSION

The Siouxland chapter of the American Association of Medical Assistants, Iowa Society, will host a seminar September 29 at St. Luke's Medical Center in Sioux City.

Guest speaker for the event will be Dr. Jerry

Simmons of Sioux Falls, South Dakota. Seminar topics will include time management, organization, results orientation, leadership, communications, motivation and human relations. CEU credit has been requested.

For further information please contact Mary Bechler, CMA-A, seminar chairman, at 2616 Pierce Street, Sioux City, Iowa; telephone — 712/255-8038.



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PRECAUTIONS: As with other antibacterial preparations, prolonged use may result in overgrowth of non-susceptible organisms, including fungi. Appropriate measures should be taken if this occurs.

ADVERSE REACTIONS: Neomycin is a not uncommon cutaneous sensitizer. Articles in the current literature indicate an increase in the prevalence of persons allergic to neomycin. Ototoxicity and nephrotoxicity have been reported (see Warning section).

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OUR MAN ON EDUCATION

RICHARD M. CAPLAN, M.D.

TO LEARN FROM THE PATIENT

WILLIAM OSLER, through his writing, lecturing and behavior, urged physicians and medical students to learn medicine from the patient. He urged that one use the patient as a textbook, for there the disease exists dynamically and there one may learn best from direct observation. This belief prompted him to help establish a new medical school (Johns Hopkins) that employed the "radical" innovation we now call clinical clerkships. He thought this particular contribution so important that he chose for his epitaph, "I taught medical students in the wards."

That one may learn medicine, in general, from patients was clear to Osler. Also clear to him was that one may learn from the individual patient what one needs to know to best help him. He was among those who said, in effect, that if you will listen carefully, the patient will tell you what is wrong. This is particularly easy to acknowledge if one expands the word "listen" to "listen and examine carefully."

A New Zealand family practitioner, Dr. I. Marsh, expanded this idea with an interesting twist in a recent article (J. Roy Coll. of Gen. Pr., 30:712, 1980). He argues that a physician is the pupil, learning about the patient under the tutelage of the patient. With this teacher-

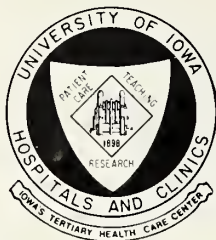
learner paradigm in mind, Dr. Marsh goes on to apply certain educational concepts first enumerated by Bloom as a taxonomy of learning. Bloom described a domain he called cognitive (facts and knowledge), another called affective (emotions and attitudes) and a third called psychomotor (physical skills). The cognitive skills involve a hierarchy from simple recognition and recall, through comprehension, application, analysis and synthesis, and ultimately evaluation. The affective domain involves willingness to pay attention, to respond, to express commitment, and ultimately to organize, characterize and apply value judgements. Marsh reminds us that the interaction between physician and patient and what the physician must learn ought to involve, at its finest expression, a maximum of intellectual, problem-solving skill combined with a maximum in the hierarchy of attending, responding, and giving commitment. Knowing and caring are words that characterize these two domains. Knowing is much easier to measure than caring.

"That one may learn medicine in general, from patients was clear to Osler. . . . He was among those who said, in effect, that if you will listen carefully, the patient will tell you what is wrong."

Continuing physician education, and medical student education as well, deals overwhelmingly with facts and intellectual skills. Too little attention is given to affective processes because we don't yet know as well how to do a good job of teaching them. In fact, we often argue that those skills can't be taught, that they are somehow built-in — either there or not there and everybody is stuck with it. I believe we are entitled to greater optimism than that, for progress is being made slowly in understanding how to assess and modulate attitudes. Better doctoring still seems to be associated in patients' minds with more caring rather than more knowing. But these do not and need not exclude each other. In fact, if we just will, this situation is one that permits us to eat our cake and have it, too.

Dr. Caplan is Associate Dean for Continuing Medical Education at The University of Iowa College of Medicine.

DRUG THERAPY REVIEW



UNIVERSITY OF IOWA HOSPITALS AND CLINICS

REYNOLD SPECTOR, M.D., Editor

Editor's Note — The toxicity of the common cardiovascular drugs is substantial. Drs. McEniry and Skorton have reviewed the Adverse Reactions to Cardiovascular Drugs. Part I appeared in the July issue of the JOURNAL.

ADVERSE REACTIONS TO CARDIOVASCULAR DRUGS (Part II — Antiarrhythmic Agents)

IN THE SECOND PORTION of this article, we will review briefly the adverse effects of the most commonly used antiarrhythmic agents: quinidine, disopyramide, procainamide and lidocaine.

Adverse effects of antiarrhythmics are important to consider in two contexts. First, these drugs commonly cause cardiac and noncardiac side effects, some of which are life threatening. Second, the indications for the use of these drugs are in many cases controversial (such as the use of antiarrhythmics to treat asymptomatic ventricular ectopic beats in a person with heart disease). This uncertain benefit-risk ratio

makes an appreciation of the adverse effects of this class of agents especially important.

QUINIDINE

Quinidine is used for both supraventricular and ventricular arrhythmias and frequently causes adverse reactions, which occurred in 14% of 652 consecutively hospitalized patients on quinidine in one study.⁶ Cardiac and hematologic reactions are the most serious. Quinidine may cause AV block and, if used in patients with preexisting AV block and ventricular escape rhythm, may cause asystole because of its depressant effect on automaticity. By slowing the atrial rate, the drug may increase the ventricular response in patients in atrial fibrillation and flutter; such patients should be adequately digitalized to prevent this. Quinidine may cause profound bradycardia in patients with sinus node disease. Ventricular arrhythmias of life-threatening nature may occur at toxic plasma concentrations. The QRS duration may be used to monitor therapy because it correlates with plasma concentration. A 25% or less increase in the QRS is expected, but a 50% increase calls for a reduction in dosage. Recurrent ventricular arrhythmias may be a manifestation of quinidine toxicity and an indication for stopping the drug, rather than giving more antiarrhythmic. The QRS duration and plasma levels may help in distinguishing drug toxicity from resistant arrhythmias.⁷

Quinidine may cause syncope or sudden death at nontoxic plasma levels. This syndrome has been called "quinidine syncope" and results from repetitive, short bursts of ventricular tachycardia or fibrillation. It may occur at very low total doses and within the first 24 hours after starting the drug. The QRS duration is not usually prolonged, but there usually is a significant lengthening of the QT interval or the development of large U waves. Many of the patients are on digoxin when begun on quinidine, and some of the reactions may be related to the previously mentioned interaction between these drugs. Quinidine should not be given to those with QT prolongation or markedly prolonged QT intervals after starting therapy.⁷

Quinidine may cause peripheral vasodilation and myocardial depression resulting in hypotension, but this is rarely of clinical significance when given orally.

Life-threatening thrombocytopenia may re-

This information for Iowa physicians is furnished and sponsored by the University of Iowa Hospitals and Clinics.

sult from quinidine therapy. Rarely, hemolytic anemia may result by a similar mechanism. A granulocytosis and hypoplastic anemia have also been reported.

Nausea, vomiting, and especially diarrhea often necessitate termination of quinidine therapy. Febrile reactions may occur within one to two weeks of beginning quinidine. Hepatotoxicity has been reported, usually associated with fever, within two weeks of starting therapy. A variety of dermatologic reactions may occur.

Cinchonism may occur as with quinine. A mild reaction may include tinnitus, auditory and visual impairment, and nausea; more severe reactions include headache, photophobia, flushing, vomiting, abdominal pain, and CNS symptoms from confusion to psychosis.⁷ A slowly progressive dementia which reversed dramatically when long-term quinidine therapy was stopped has been reported in one patient.

Quinidine is metabolized mostly by the liver, but some is excreted in urine. The effect of renal and heart failure on quinidine plasma levels is controversial, but care should be used in administering the drug in these circumstances. Therapeutic plasma levels are 3 to 6 µg/ml.

DISOPYRAMIDE

Disopyramide was released for use in the United States in 1978 and since has attained wide use for both atrial and ventricular tachyarrhythmias. Although chemically different, its electrophysiologic properties are very similar to those of quinidine and procainamide. Disopyramide also has more profound negative inotropic effects than quinidine or procainamide. Of 100 patients in one study given disopyramide, 16 developed acute congestive heart failure, in some after only a few doses. Twelve of the 16 had a previous history of heart failure; of the total group of 100 patients, 55% of those with a previous history of failure developed acute cardiac decompensation on disopyramide compared to only 3% of those with no history of failure.⁸

Disopyramide at toxic plasma concentrations causes QRS widening and may cause ventricular arrhythmias. Marked QT prolongation with normal QRS duration and repeated episodes of ventricular tachycardia or fibrilla-

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Hemorrhoidal Suppositories with Hydrocortisone Acetate

ANUSOL-HC® CREAM

Rectal Cream with Hydrocortisone Acetate

Caution: Federal law prohibits dispensing without prescription.

Description: Each Anusol-HC Suppository contains hydrocortisone acetate, 10.0 mg; bismuth subgallate, 2.25%; bismuth resorcin compound, 1.75%; benzyl benzoate, 1.2%; Peruvian balsam, 1.8%; zinc oxide, 11.0%; also contains the following inactive ingredients: dibasic calcium phosphate, and certified coloring in a hydrogenated vegetable oil base.

Each gram of Anusol-HC Cream contains hydrocortisone acetate, 5.0 mg; bismuth subgallate, 22.5 mg; bismuth resorcin compound, 17.5 mg; benzyl benzoate, 12.0 mg; Peruvian balsam, 18.0 mg; zinc oxide, 110.0 mg; also contains the following inactive ingredients: propylene glycol, propylparaben, methylparaben, polysorbate 60 and sorbitan monostearate in a water-miscible base of mineral oil, glyceryl stearate and water.

Anusol-HC Suppositories and Anusol-HC Cream help to relieve pain, itching and discomfort arising from irritated anorectal tissues. These preparations have a soothing, lubricant action on mucous membranes, and the antiinflammatory action of hydrocortisone acetate in Anusol-HC helps to reduce hyperemia and swelling.

The hydrocortisone acetate in Anusol-HC is primarily effective because of its antiinflammatory, antipruritic and vasoconstrictive actions.

Indications and Usage: Anusol-HC Suppositories and Anusol-HC Cream are adjunctive therapy for the symptomatic relief of pain, itching and discomfort in: external and internal hemorrhoids, proctitis, papillitis, cryptitis, anal fissures, incomplete fistulas, pruritus ani and relief of local pain and discomfort following anorectal surgery.

Anusol-HC is especially indicated when inflammation is present. After acute symptoms subside, most patients can be maintained on regular Anusol® Suppositories or Ointment.

Contraindications: Anusol-HC Suppositories and Anusol-HC Cream are contraindicated in those patients with a history of hypersensitivity to any of the components of the preparations.

Warnings: The safe use of topical steroids during pregnancy has not been fully established. Therefore, during pregnancy, they should not be used unnecessarily on extensive areas, in large amounts or for prolonged periods of time.

Precautions: General: Symptomatic relief should not delay definitive diagnoses or treatment.

Prolonged or excessive use of corticosteroids might produce systemic effects.

If irritation develops, Anusol-HC Suppositories and Anusol-HC Cream should be discontinued and appropriate therapy instituted.

In the presence of an infection the use of an appropriate antifungal or antibacterial agent should be instituted. If a favorable response does not occur promptly, the corticosteroid should be discontinued until the infection has been adequately controlled.

Anusol-HC is not for ophthalmic use.

Pregnancy

See "WARNINGS"

Pediatric Use

Care should be taken when using the corticosteroid hydrocortisone acetate in children and infants.

Dosage and Administration: Anusol-HC Suppositories—

Adults: Remove foil wrapper and insert suppository into the anus. Insert one suppository in the morning and one at bedtime for 3 to 6 days or until inflammation subsides. Then maintain comfort with regular Anusol Suppositories.

Anusol-HC Cream—Adults: After gentle bathing and drying of the anal area, remove tube cap and apply to the exterior surface and gently rub in. For internal use, attach the plastic applicator and insert into the anus by applying gentle continuous pressure. Then squeeze the tube to deliver medication. Cream should be applied 3 or 4 times a day for 3 to 6 days until inflammation subsides. Then maintain comfort with regular Anusol Ointment.

NOTE: If staining from either of the above products occurs, the stain may be removed from fabric by hand or machine washing with household detergent.

How Supplied: Anusol-HC Suppositories—boxes of 12 (N 0071-1089-07) and boxes of 24 (N 0071-1089-13) in silver foil strips with Anusol-HC printed in black.

Anusol-HC Cream—one-ounce tube (N 0071-3090-13) with plastic applicator.

Store between 59°-96°F (15°-30°C).
1089C010

DRUG THERAPY REVIEW

tion very similar to "quinidine syncope" may also be caused by disopyramide.

Disopyramide should be withheld from patients with significant ventricular dysfunction and those who develop marked QT prolongation or have a history of such with quinidine. Patients with renal dysfunction have prolonged clearance and should receive a reduced dose.

Disopyramide has more pronounced atropine-like effects than the other agents and often causes dry mouth, urinary retention, blurred vision, and constipation. It may cause gastrointestinal symptoms similar to but less frequently than quinidine. Cholestatic jaundice has also been reported.

PROCAINAMIDE

Procainamide has electrophysiologic effects and toxicity very similar to those described for quinidine. The prolonged QT syndrome has not been described with procainamide.

The extracardiac adverse effects of procainamide differ from those with quinidine. In a series of 488 hospitalized patients receiving procainamide, 1.4% had life-threatening cardiac toxicity and 7.8% had extracardiac or non-life-threatening cardiac toxicity for a total of 9.2% incidence of acute adverse reactions.⁹ No deaths were attributed to procainamide.

Gastrointestinal side effects occur much less frequently than with quinidine. Drug fever may occur, usually within one to two weeks from the start of therapy. Agranulocytosis is a well documented but an uncommon adverse reaction to procainamide and is independent of the lupus syndrome. Symptoms of fever or sore throat should alert the physician to the possibility of agranulocytosis in patients on procainamide. Thrombocytopenia and anemia have also been reported as possible adverse reactions to procainamide. There have been occasional reports of hepatic toxicity to procainamide.

Drug-induced lupus erythematosus is a well-recognized adverse reaction to long-term therapy with procainamide. Antinuclear antibodies (ANA) develop in 50 to 80% of patients

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DRUG THERAPY REVIEW

on long-term procainamide; the lupus syndrome develops in 20% of those with ANA. The syndrome is readily distinguishable from idiopathic SLE. Renal and central nervous system involvement are rare, hematologic toxicity is less common and usually mild, and antibodies to native DNA are absent. Arthralgia or arthritis, myalgia, and pleural involvement are the most common features. Skin rash is much less common than in the idiopathic variety. Pulmonary parenchymal involvement is more common.⁷ Symptoms usually resolve after withdrawal of the drug, although the ANA may persist longer.

Cardiac toxicity to procainamide correlates with plasma levels; therapeutic levels are 4 to 8 $\mu\text{g/ml}$. Decreased renal function decreases the clearance of procainamide and N-acetylprocainamide (NAPA), the principal metabolite of procainamide. Monitoring of procainamide and NAPA levels allows differentiation of resistant arrhythmia from subtherapeutic plasma levels and prevention of toxic accumulation when renal function is decreased.¹⁰

LIDOCAINE

Lidocaine has found widespread use as the parenteral agent of choice for acute treatment of significant ventricular ectopic activity in the setting of acute myocardial ischemia. Recently, its use has been advocated as prophylactic treatment in the patient admitted to hospital with presumed or suspected ischemic cardiac disease. Cardiac side effects are uncommon, and the drug is usually well tolerated, although sinus node arrest, heart block, and hypotension have been seen. The major toxicity of lidocaine is to the central nervous system, with subtle symptoms of confusion and drowsiness sometimes seen at serum levels of 5 $\mu\text{g/ml}$, and depressed sensorium or seizures at levels above 5 $\mu\text{g/ml}$. Treatment for the seizure activity is supportive with discontinuation of the infusion.

CONCLUSION

The adverse reactions to cardiac drugs may be life threatening. Consequently, these drugs

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DRUG THERAPY REVIEW

must be given only when a clear-cut indication exists. By limiting the use of these agents and by closely monitoring the patients for clinical evidence of adverse effects and with judicious use of plasma drug levels, when available, the incidence of serious adverse reactions to this commonly used set of drugs may be substantially reduced. — David W. McEniry, M.D., Fellow in General Medicine, and David J. Skorton, M.D., Assistant Professor of Medicine, Department of Internal Medicine, University of Iowa College of Medicine.

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CHANGES IN MEASLES-RUBELLA

School Immunization Requirements

As a result of extensive studies of measles outbreaks in 1976, the American Academy of Pediatrics Committee on Infectious Diseases and the United States Public Health Service Advisory Committee on Immunization Practices have recommended measles immunization be deferred until a child reaches 15 months of age. The same two committees have recommended that measles or rubella immunizations given at less than 12 months of age be repeated after the child reaches 15 months of age.

In the fall of 1977 the Iowa Immunization Law went into effect with the same requirements.

On February 1, 1981, the Iowa immunization regulations were amended. The new regulation requires that a child receiving the measles and rubella immunization after February 1, 1981, be 15 months of age. Thus, if a child receiving the inoculation after February 1 is less than 15 months of age, the inoculation will have to be repeated to meet requirements for entrance into school or child care center.

Children inoculated prior to February 1, 1981, who were at least 12 months of age but

less than 15 months at the time of immunization, are not required to be reinoculated.

The following outline summarizes recommended measles and rubella immunization schedules based on age at immunization.

- A. Immunized prior to February, 1981, and the age of the child was:
 - (1) Less than 12 months — Reimmunize for measles and rubella
 - (2) Between 12 months-15 months — Acceptable immunization, optional reimmunization
 - (3) Or over 15 months — Acceptable immunization
- B. Immunized on or after February 1, 1981 and age of child was:
 - (1) Under 15 months — Reimmunize for measles and rubella
 - (2) Over 15 months — Acceptable immunization

The effect of the immunization law on disease incidence in Iowa, especially measles, has been dramatic. During calendar year 1980 there was only one outbreak of measles (20 cases). All but one case were in children not covered by the school law. To date in 1981 there has been only one confirmed case of measles, in a child too young (9 months) to be immunized. This child was exposed to measles at a family reunion in Spain. Due to prompt reporting and follow-up by the physician there was no spread to the community from this case.

Continued cooperation between the medical community, schools (especially the school nurses), public health nurses and the public will ensure that Iowa remains measles-free in the future.

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June 1981 Morbidity Report

Disease	June 1981 Total	1981 to Date	1980 to Date	Most June Coses Reported From These Counties
Amebiasis	3	5	7	Boone
Brucellosis	0	0	4	
Chickenpox	381	6908	7379	Linn, Dollos, Dubuque
Cytomegalovirus	0	10	12	
Eaton's Agent infection	2	13	9	Muscatine, Polk
Encephalitis, virol	1	8	8	Linn
Erythema infectiosum	76	1145	396	Dollos, Block Hawk, Cedar
Gastroenteritis (GIV)	171	12139	13230	Linn, Pottawottomie
Giardiasis	6	19	12	Cerro Gordo, Dubuque
Hepatitis, A	13	143	75	Polk, Linn, Scott
Hepatitis, B	12	45	43	Linn, Polk, Scott
type unspecified	4	30	40	Scattered
Herpes Simplex	13	98	47	Johnson, Polk, Linn
Herpes Zoster	0	4	1	
Histoplasmosis	1	6	14	Mills
Infectious mononucleosis	2	188	206	Block Hawk
Influenza, lab confirmed	0	191	108	
Influenza-like illness (URI)	977	48228	48347	Johnson, Shelby
Meningitis				
oseptic	1	25	11	Polk
bacterial	6	74	68	Scattered
meningococcal	2	18	6	Block Hawk, Warren
Mumps	2	40	35	Linn, Pottawottomie
Pertussis	0	2	0	
Robies in animals	78	480	206	Keokuk, Tomo, Washington
Rheumatic fever	0	6	0	
Rubella				
(German measles)	1	4	4	Polk
Rubeola (measles)	0	1	20	
Salmonella	24	116	55	Linn, Polk
Shigellosis	1	17	29	Wapello
Tuberculosis				
total ill	6	49	36	Scott
bact. pos.	5	31	27	Scattered
Venereal diseases:				
Gonorrhea	556	2405	2242	Polk, Scott, Block Hawk
Syphilis	1	13	8	Block Hawk

Laboratory Virus Diagnosis Without Specified Clinical Syndrome: Guillain Barre Syndrome — 1, Butler, 1, Clinton, 1, Polk; Legionnaire's — 1, Soc, 1, Scott; Reye's Syndrome — 1, Lee; Scarlet Fever — 1, Clinton, 1, Dollos, 1, Dubuque, 1, Polk; Psittacosis — 1, Muscatine; Blastomycosis — 1, Polk; Complobacter — 4, Dubuque, 3, Polk, 1, Warren; Toxic Shock Syndrome — 1, Johnson.

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ABOUT IOWA PHYSICIANS

Dr. Edward Nassif, Ames, was guest speaker at a recent meeting of the Hardin County Medical Society in Iowa Falls. Dr. Nassif spoke on pharmacotherapy in asthma. . . . **Dr. Mark A. Marner** has joined **Drs. K. L. Schminke** and **J. A. Ver Huel** to practice internal medicine in Fort Dodge. Dr. Marner received the M.D. degree at U. of I. College of Medicine and completed his internal medicine residency at Iowa Methodist Medical Center in Des Moines. Prior to locating in Fort Dodge, Dr. Marner served with the National Health Service Corps

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in southern Illinois. . . . **Dr. John M. O'Shea**, Clinton, was guest speaker at a recent meeting of the Riverbend Bicycle Club. Dr. O'Shea discussed the benefits of bicycling, but described as well the potential for knee damage from improper riding methods. . . . **Dr. LeRoy Johnson**, Ames, recently presented a lecture on vascular surgery to Iowa State University veterinary medicine students. . . . **Dr. Floyd J. Filer, Jr.**, professor of the U. of I. Department of Pediatrics, was appointed recently to the Expert Advisory Panel of the United States Pharmacopeial Convention. . . . **Dr. James E. Coker**, Sioux City, recently was named a fellow of the American College of Physicians.

New officers of the Linn County Medical Society are **Dr. Marian L. Barnes**, president; **Dr. Joseph F. Galles**, president-elect; **Dr. Dale D. Morgan**, vice president; and **Dr. Dean H. Bemus**, secretary-treasurer. . . . At the annual meeting of the Iowa Clinical Surgical Society, **Dr. Vernon Plager**, Waterloo, was named president; **Dr. Leonard Boggs**, Sioux City, president-elect; and **Dr. John M. Syverud**, Davenport, secretary-treasurer. . . . **Dr. Alan Munson**, Ames, was guest speaker at a recent meeting of the Nurses Association of American College of Obstetrics and Gynecology in Waterloo. Dr. Munson spoke on "Recurrent Abortions." . . . **Dr. Kyle VerSteeg**, Fort Dodge, was guest speaker at recent meeting of the Wright County Medical Society. Dr. VerSteeg spoke on "Gallstone Pancreatitis." . . . **Dr. William B. Bean**, Sir William Osler Professor, Emeritus Professor of Medicine, U. of I. Department of Internal Medicine, recently addressed the American Osler Society, Hamilton, Ontario, Canada. His topic, "On Brains and Osler's Brain." Dr. Bean also was selected to give the bicentennial lecture celebrating the founding of the Massachusetts Medical Society in Salem, Massachusetts. His lecture was entitled, "What and Who Give a Person the Right to Take Care of the Sick: A Survey of the Origins of Medical Societies, Licensing Boards, State Laws, Royal Charters, University Guilds and Specialty Boards."

Dr. S. Donald Zaentz, Ames, was guest speaker at recent meeting of the Grundy County Hospital medical and nursing staff. Dr. Zaentz spoke on new approaches in cancer chem-

(Please turn to page 352)

...takes dietary restriction, regular exercise, behavior modification, and sometimes the addition of an effective anorectic.

prescribe

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the #1 prescribed anorectic

An effective short-term adjunct in an indicated weight loss program

Overweight patients in certain diagnostic categories often require strict obesity control. Diethylpropion hydrochloride has been reported useful in obese patients with certain complications. While it is not suggested that Tenuate in any way reduces these complications in the overweight, it may have a useful place as a short-term adjunct in a prescribed dietary regimen. Tenuate should not be administered to patients with severe hypertension; see additional Precautions and Adverse Reactions on this page.

In uncomplicated obesity

Many patients, on the other hand, present with excess fat but no disease. While this condition is often termed uncomplicated obesity, complications of both a social and a psychologic nature may be distressingly real for the patients. In these cases, a short-term regimen of Tenuate can help reinforce your dietary counsel during the important early weeks of an indicated weight loss program.

Clinical effectiveness

The anorectic effectiveness of diethylpropion hydrochloride is well documented. No less than 18 separate double-blind, placebo-controlled studies attest to its usefulness in daily practice.¹ And the unique chemistry of Tenuate provides "... anorectic potency with minimal overt central nervous system or cardiovascular stimulation."² Compared with the amphetamines, diethylpropion has minimal potential for abuse.

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References: 1. Citations available on request from Merrell Dow Pharmaceuticals Inc., Cincinnati, Ohio 45215. 2. Hoekenga M T et al: A comprehensive review of diethylpropion hydrochloride. In *Central Mechanisms of Anorectic Drugs*, S. Garattini and R. Samanin, Ed., New York. Raven Press, 1978, pp. 391-404.

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Tenuate Dospan[®] ^{IV}
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Brief Summary

INDICATION: Tenuate and Tenuate Dospan are indicated in the management of exogenous obesity as a short-term adjunct (a few weeks) in a regimen of weight reduction based on caloric restriction. The limited usefulness of agents of this class should be measured against possible risk factors inherent in their use such as those described below.

CONTRAINDICATIONS: Advanced arteriosclerosis, hyperthyroidism, known hypersensitivity, or idiosyncrasy to the sympathomimetic amines, glaucoma. Agitated states. Patients with a history of drug abuse. During or within 14 days following the administration of monoamine oxidase inhibitors, (hypertensive crises may result).

WARNINGS: If tolerance develops, the recommended dose should not be exceeded in an attempt to increase the effect; rather, the drug should be discontinued. Tenuate may impair the ability of the patient to engage in potentially hazardous activities such as operating machinery or driving a motor vehicle; the patient should therefore be cautioned accordingly. When central nervous system active agents are used, consideration must always be given to the possibility of adverse interactions with alcohol. **Drug Dependence:** Tenuate has some chemical and pharmacologic similarities to the amphetamines and other related stimulant drugs that have been extensively abused. There have been reports of subjects becoming psychologically dependent on diethylpropion. The possibility of abuse should be kept in mind when evaluating the desirability of including a drug as part of a weight reduction program. Abuse of amphetamines and related drugs may be associated with varying degrees of psychologic dependence and social dysfunction which, in the case of certain drugs, may be severe. There are reports of patients who have increased the dosage to many times that recommended. Abrupt cessation following prolonged high dosage administration results in extreme fatigue and mental depression; changes are also noted on the sleep EEG. Manifestations of chronic intoxication with anorectic drugs include severe dermatoses, marked insomnia, irritability, hyperactivity, and personality changes. The most severe manifestation of chronic intoxications is psychosis, often clinically indistinguishable from schizophrenia. **Use in Pregnancy:** Although rat and human reproductive studies have not indicated adverse effects, the use of Tenuate by women who are pregnant or may become pregnant requires that the potential benefits be weighed against the potential risks. **Use in Children:** Tenuate is not recommended for use in children under 12 years of age.

PRECAUTIONS: Caution is to be exercised in prescribing Tenuate for patients with hypertension or with symptomatic cardiovascular disease, including arrhythmias. Tenuate should not be administered to patients with severe hypertension. Insulin requirements in diabetes mellitus may be altered in association with the use of Tenuate and the concomitant dietary regimen. Tenuate may decrease the hypotensive effect of guanethidine. The least amount feasible should be prescribed or dispensed at one time in order to minimize the possibility of overdosage. Reports suggest that Tenuate may increase convulsions in some epileptics. Therefore, epileptics receiving Tenuate should be carefully monitored. Titration of dose or discontinuance of Tenuate may be necessary.

ADVERSE REACTIONS: **Cardiovascular:** Palpitation, tachycardia, elevation of blood pressure, precordial pain, arrhythmia. One published report described T-wave changes in the ECG of a healthy young male after ingestion of diethylpropion hydrochloride. **Central Nervous System:** Overstimulation, nervousness, restlessness, dizziness, jitteriness, insomnia, anxiety, euphoria, depression, dysphoria, tremor, dyskinesia, mydriasis, drowsiness, malaise, headache, rarely psychotic episodes at recommended doses. In a few epileptics an increase in convulsive episodes has been reported. **Gastrointestinal:** Dryness of the mouth, unpleasant taste, nausea, vomiting, abdominal discomfort, diarrhea, constipation, other gastrointestinal disturbances. **Allergic:** Urticaria, rash, ecchymosis, erythema. **Endocrine:** Impotence, changes in libido, gynecomastia, menstrual upset. **Hematopoietic System:** Bone marrow depression, agranulocytosis, leukopenia. **Miscellaneous:** A variety of miscellaneous adverse reactions has been reported by physicians. These include complaints such as dyspnea, hair loss, muscle pain, dysuria, increased sweating, and polyuria.

DOSEAGE AND ADMINISTRATION: Tenuate (diethylpropion hydrochloride): One 25 mg. tablet three times daily, one hour before meals, and in mid-evening if desired to overcome night hunger. Tenuate Dospan (diethylpropion hydrochloride) controlled-release: One 75 mg. tablet daily, swallowed whole, in mid-morning. Tenuate is not recommended for use in children under 12 years of age.

OVERDOSAGE: Manifestations of acute overdosage include restlessness, tremor, hyperreflexia, rapid respiration, confusion, assaultiveness, hallucinations, panic states. Fatigue and depression usually follow the central stimulation. Cardiovascular effects include arrhythmias, hypertension or hypotension and circulatory collapse. Gastrointestinal symptoms include nausea, vomiting, diarrhea, and abdominal cramps. Overdose of pharmacologically similar compounds has resulted in fatal poisoning, usually terminating in convulsions and coma. Management of acute Tenuate intoxication is largely symptomatic and includes lavage and sedation with a barbiturate. Experience with hemodialysis or peritoneal dialysis is inadequate to permit recommendation in this regard. Intravenous phenolamine (Regitine[®]) has been suggested on pharmacologic grounds for possible acute, severe hypertension, if this complicates Tenuate overdosage.

Product Information as of June, 1980

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otherapy. . . . **Dr. David MacMillan**, Waverly, was elected president of the executive council of the Iowa Chapter of the Great Plains Perinatal Organization at the annual meeting of the group in Des Moines. . . . **Dr. Byron T. Beasley**, Mason City, was guest speaker at a recent Mason City Workshop on heart disease. Dr. Beasley discussed heart conditions and appropriate treatment. . . . **Dr. E. V. Andrew**, Maquoketa, recently was honored for his 50 years in medical practice. Semi-retired in recent years, Dr. Andrew writes a weekly column, "The Traveling Iconoclast," for the *SENTINEL-PRESS*. . . . **Dr. William Rosenfeld**, Mason City, has returned to Thailand with the American Refugee Committee as a medical volunteer to serve Khmer refugees at an 80-bed ARC hospital until the end of July. Dr. Rosenfeld served in Cambodia from January through May 1980. . . . **Drs. Mark Brodersen** and **Robert Gitchell**, Ames physicians, were guest speakers at a recent meeting of the Boone County Medical Society. Their topic "Office Orthopedics for General Practitioners." . . . **Dr. G. Earl Jurgenson**, Meservey, was hon-

ored locally for his 43 years of medical service to the Meservey community.

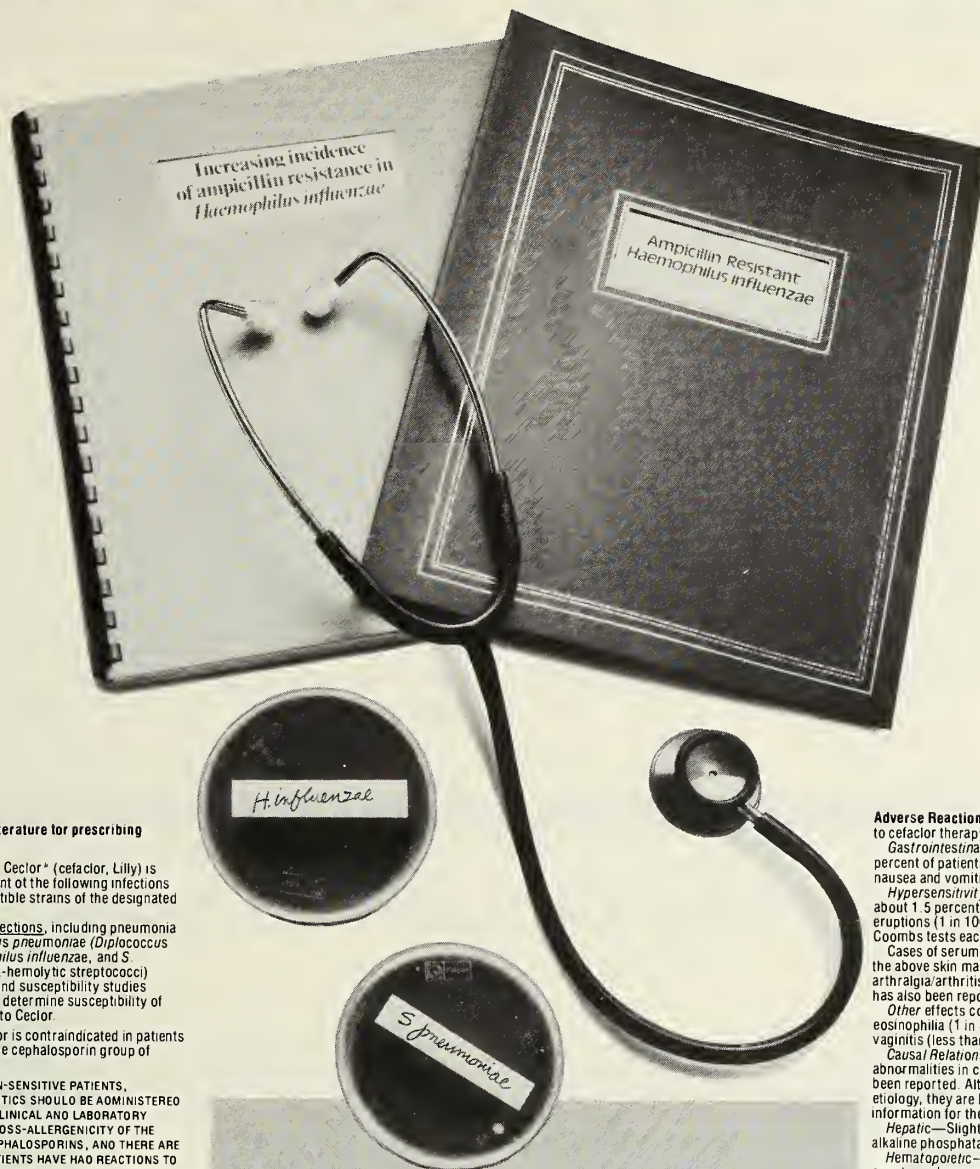
Dr. Subhash Sahai, Webster City, was the guest speaker at recent meeting of Webster City Kiwanis Club. Dr. Sahai spoke on cardiopulmonary resuscitation.

Dr. G. D. Jenkins, Burlington, was honored at the annual meeting of the Iowa Urological Society for his longtime membership. Dr. Jenkins, a Burlington urologist since 1933, is the last IUS charter member in active practice. . . . Dubuque Surgery, P.C., recently was established by three physicians in that community. They are — **Dr. Paul J. Laube**, **Dr. Luke C. Faber** and **Dr. R. V. Mullapudi**. . . . **Dr. John K. Uchiyama**, Des Moines, has been named "internist of the year" by the Iowa Clinical Society of Internal Medicine. The award was presented at a joint session of the Society and the American College of Physicians in Iowa City. . . . Four Iowa City surgeons, **Drs. Janusz Bardach**, **William R. Panje**, **Roger I. Ceilley** and **Robert A. Bumstead**, served on the faculty at the spring scientific meeting of the American Academy of Facial Plastic and Reconstructive Surgery in Vancouver, British Columbia. Dr. Bardach presented a paper describing treatment of self-inflicted shotgun wounds of the face; Dr. Panje discussed "A New Method for Total Nasal Reconstruction: The Trapezius Myocutaneous Island Paddle Flap," and Dr. Ceilley and Dr. Bumstead spoke on "Auricular Malignancies: Identification of High-Risk Lesions and Selection of Method of Reconstruction."

Dr. John Walck recently began family practice at Medical Associates in LeMars. Dr. Walck received his medical education in Queensland, Australia and completed his family practice residency in Sioux City. . . . **Dr. James F. Boysen** has been named president of the medical staff at St. Luke's Medical Center in Sioux City. Other officers are — **Dr. David G. Paulsrud**, vice president and **Dr. Alan Pechacek**, secretary-treasurer. All are Sioux City physicians. . . . **Dr. William B. Bean**, professor emeritus, Department of Internal Medicine, U. of I. College of Medicine, presented

(Please turn to page 354)

An added complication... in the treatment of bacterial bronchitis*



Brief Summary. Consult the package literature for prescribing information.

Indications and Usage: Cefclor* (cefclor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms:

Lower respiratory infections, including pneumonia caused by *Streptococcus pneumoniae* (*Diplococcus pneumoniae*), *Haemophilus influenzae*, and *S. pyogenes* (group A beta-hemolytic streptococci).

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Cefclor.

Contraindication: Cefclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

Warnings: In penicillin-sensitive patients, cephalosporin antibiotics should be administered CAUTIOUSLY. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS, AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS TO BOTH DRUG CLASSES (INCLUDING ANAPHYLAXIS AFTER PARENTERAL USE).

Antibiotics, including Cefclor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs.

Precautions: If an allergic reaction to cefclor occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e.g., pressor amines, antihistamines, or corticosteroids.

Prolonged use of cefclor may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs test may be due to the drug.

Cefclor should be administered with caution in the presence of markedly impaired renal function. Under such a condition, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended.

As a result of administration of Cefclor, a false-positive reaction for glucose in the urine may occur. This has been observed with Benedict's and Fehling's solutions and also with Clinitest® tablets but not with Tes-Tape® (Glucose Enzymatic Test Strip, USP, Lilly).

Usage in Pregnancy—Although no teratogenic or antifertility effects were seen in reproduction studies in mice and rats receiving up to 12 times the maximum human dose or in ferrets given three times the maximum human dose, the safety of this drug for use in human pregnancy has not been established. The benefits of the drug in pregnant women should be weighed against a possible risk to the fetus.

Usage in Infancy—Safety of this product for use in infants less than one month of age has not been established.

Some ampicillin-resistant strains of *Haemophilus influenzae*—a recognized complication of bacterial bronchitis*—are sensitive to treatment with Cefclor.¹⁻⁶

In clinical trials, patients with bacterial bronchitis due to susceptible strains of *Streptococcus pneumoniae*, *H. influenzae*, *S. pyogenes* (group A beta-hemolytic streptococci), or multiple organisms achieved a satisfactory clinical response with Cefclor.⁷

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cefclor

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Adverse Reactions: Adverse effects considered related to cefclor therapy are uncommon and are listed below: **Gastrointestinal** symptoms occur in about 2.5 percent of patients and include diarrhea (1 in 70) and nausea and vomiting (1 in 90).

Hypersensitivity reactions have been reported in about 1.5 percent of patients and include morbilliform eruptions (1 in 100), pruritus, urticaria, and positive Coombs tests each occur in less than 1 in 200 patients.

Cases of serum-sickness-like reactions, including the above skin manifestations, fever, and arthralgia/arthritis, have been reported. Anaphylaxis has also been reported.

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients).

Causal Relationship Uncertain—Transitory abnormalities in clinical laboratory test results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician.

Hepatic—Slight elevations in SGOT, SGPT, or alkaline phosphatase values (1 in 40).

Hematopoietic—Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40).

Renal—Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200).

[103080C]

*Many authorities attribute acute infectious exacerbation of chronic bronchitis to either *S. pneumoniae* or *H. influenzae*.

Note: Cefclor* (cefclor) is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

References

1. Antimicrob. Agents Chemother., 8: 91, 1975.
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5. Current Chemotherapy (edited by W. Siegenthaler and R. Luthy), H. 680. Washington, D.C.: American Society for Microbiology, 1978.
6. Antimicrob. Agents Chemother., 13: 861, 1978.
7. Data on file, Eli Lilly and Company.
8. Principles and Practice of Infectious Diseases (edited by G. L. Mandell, R. G. Douglas, Jr., and J. E. Bennett), p. 487. New York: John Wiley & Sons, 1979.

Additional information available to the profession on request from
Eli Lilly and Company
Indianapolis, Indiana 46285.
Eli Lilly Industries, Inc.
Carolina, Puerto Rico 00630



100061

the centennial lecture at the 100th anniversary of the founding of the University of Nebraska Medical School in Omaha, Nebraska. His topic "The Self as Subject: A Study of Auto-experimentation and Auto-observation."

DEATHS

Dr. Charles P. Hawkins, 61, Clarion, died June 25 at Iowa Methodist Medical Center in Des Moines. Dr. Hawkins received the M.D. degree at Marquette University in Milwaukee, Wisconsin and interned at University Hospitals in Iowa City. He began his medical practice in Clarion in 1951. Dr. Hawkins was a charter member of the American Academy of Family Physicians and a diplomate of the American Board of Family Physicians. He was a past president of the Wright County Medical Society and past president of Blue Shield of Iowa. He was well known and respected for his long service as a member of the IMS House of Delegates.

Dr. E. G. Kettelkamp, 88, longtime Monona physician, died June 7 at Community Memorial Hospital in Postville. Dr. Kettelkamp received the M.D. degree at University of Kansas School of Medicine and interned at Broadlawns Hospital in Des Moines. He was a life member of the Iowa Medical Society.

Dr. Clayton W. Clark, 65, Nashua, died at his home June 7. Dr. Clark received the M.D. degree at the University of Kansas School of Medicine and interned at City Hospital in Cleveland, Ohio. He began his medical practice in Nashua in 1946, retiring in 1979.

Dr. William O. Purdy, 75, Des Moines, died June 21 at Iowa Methodist Medical Center in Des Moines. Dr. Purdy received the M.D. degree at the University of Virginia. He was a former vice president and medical director for Equitable of Iowa Life Insurance Co.; past president of the Association of Life Insurance Medical Directors of America; past president of the Polk County Medical Society and past chairman of the IMS Committee on Group Insurance.

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GENERAL PRACTITIONER WANTED — Guarantee \$100,000/1st year, beautiful lake, rural Iowa-Minnesota area. Address your inquiry to No. 1542, Journal of the Iowa Medical Society, 1001 Grand Avenue, West Des Moines, Iowa 50265.

EMERGENCY MEDICINE — Physician sought for clinical opportunity in moderate volume ED located in southeastern Iowa. Hours 6 p.m.-6 a.m., Monday-Thursday. No on-call duty, excellent compensation, and professional liability insurance provided. For details, contact Michelle Grimm, 970 Executive Parkway, St. Louis, Missouri 63141; or call toll-free, 1/800/325-3982.

FOR SALE — 30-year old practice and fully equipped office available immediately in Bettendorf, Iowa. A. R. Tou Velle, M.D., has to quit practice for health reasons. Fully equipped ground floor office, 1,800 sq. ft., reception room seats 25, 3 fully equipped examining rooms, X-ray room, business office and small lab. Parking area for 40 cars. Will sell all equipment very reasonable and will rent office on graduated scale to assist buyer in establishing himself. Excellent opportunity! Will cooperate in any way possible to help physician get started. Should be seen to appreciate excellent location of office and parking and excellent condition of office and equipment. Contact A. R. Tou Velle, M.D., 2909 Olympia Drive, Bettendorf, Iowa 52722. Phone 319/355-1909.

PRACTICE OPPORTUNITY — Board certified family practice person to associate with family practice group in "Heart of the Iowa Great Lakes Area." Initial generous salary with early partnership. New office facilities adjacent to modern hospital with adequate consulting opportunities. Great area to raise children. Every conceivable recreation opportunity. Contact — D. F. Rodawig, Jr., M.D., 2700 23rd Street, Spirit Lake, Iowa 51360. 712/336-2410. Female applications especially invited.

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WANTED — STUDENT HEALTH PHYSICIAN — Having empathy with young adults. Position available January 1, 1982. Iowa license required. Excellent salary, fringe benefits and working conditions. An Affirmative Action and Equal Opportunity Employer. Contact or send application and résumé to Harley G. Feldick, M.D., Director, Student Health Service, The University of Iowa, Iowa City, Iowa 52242.

FOR SALE — FOR THE NOSTALGIC DECOR — 2 quality, vintage examining tables, 1 EKG table. Excellent condition. Collectors will be interested. Also, miscellaneous office equipment. Contact Dr. Barry L. Kricsfeld, 201 Ridge Street, Suite 300, Council Bluffs, Iowa 51501. 712/322-5532.

OCTOBER 12-13, 1981 — SOUTH DAKOTA PERINATAL ASSOCIATION SIXTH ANNUAL CONFERENCE, "Current Issues in Perinatal Care," Holiday Inn of the Northern Black Hills, Spearfish, South Dakota. 9.6 Continuing Education Credits applied for. Guest speakers include: Preston Dilts, M.D.; John Grossman, M.D.; George McCracken, M.D.; Lu-Ann Papile, M.D. Contact Maro Varcoe, R.N., Program Director, S.D.P.A., 1100 S. Euclid Avenue, Sioux Falls, South Dakota 57105. 605/339-6578.

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In The Public Interest



Physicians High In Trustworthiness

IN A SURVEY of Iowa physicians earlier this year a goodly number (88%) of the respondents either agreed or strongly agreed that a highly favorable attitude exists among patients toward their doctors.

In this same Iowa Medical Society survey, a large percentage (97%) of those answering said medical care in their area is of as high quality as it has been during the time they have been there. They indicated too that citizen access to both primary and specialty care appears to be no problem.

In a further survey response, a significant number of the replying physicians said priority attention deserves to be given to building and maintaining the favorable image the medical profession *now has*.

We say *now has* using as justification recently published and copyrighted findings of the well-known *Iowa Poll*. This is the respected scientific opinion gathering instrument of the *Des Moines Register and Tribune Company*.

On July 5, 1981, the *Des Moines Sunday Register* presented a level of trust scale showing how Iowans rank various governmental, business, religious and social institutions in this regard. In compiling its responses into a single value, the *Iowa Poll* produced what it called a confidence rating number. This rating number was drawn from responses gathered in 1,011 face-to-face in-home interviews with Iowans 18 and older. The interviews were reported to have been conducted in 106 sampling points throughout the state between April 20 and 25.

Pleasingly, the medical profession received the third highest confidence rating among the 39 entities about which inquiry was made.

Readers of the July 5 tabulation in the *Des Moines Sunday Register* will recall that God and the President of the United States ranked one

and two ahead of the medical profession. Obviously, they represent pretty stiff competition.

The medical profession has and without doubt should rank high in public confidence. Other surveys over the years — national, regional and state — have produced similar findings, with some ebb and flow. In the first *Iowa Poll* to measure level of confidence (in 1977) the medical profession ranked fourth — behind God, State Highway Patrol and banks and financial institutions.

Another important segment of Iowa health care delivery ranked high in public esteem. Hospitals placed fifth out of 39 entities in the *Iowa Poll*. Others in the top 10 (in order and excluding the previously mentioned 1, 2, 3 and 5 positions) were State Highway Patrol, organized religion and churches, banks and financial institutions, universities and colleges, local school system, and grocery and food stores.

The bottom 10 in the *Iowa Poll*, for what comparative interest it may provide, were environmental protection groups, the U.S. postal service, big industrial manufacturers, Iowa Farm Bureau, organized labor, state governmental regulatory agencies, real estate agents, federal government regulatory agencies, gas and electric companies, and farm organizations (except Farm Bureau).

So long as we are on the survey theme, one illustrative finding from the AMA's extensive *Profile of Medical Practice, 1981* may bear on the recent good marks given by the Iowa citizenry to the medical profession. The AMA data indicate physicians nationally are seeing fewer patients and spending more time with each. The AMA Profile reports in 1980 physicians had an average of 112 patient visits per week, down from 122.7 patient visits in 1979, and 130.6 in 1978. But the physician's work week in length of time for direct patient care is virtually identical to the preceding year.

All of this is quite gratifying. And challenging. *Nice going, Iowa physicians!*

August 1981

Journal of the Iowa Medical Society



THINGS YOU SHOULD KNOW

IMS LEGISLATIVE CONFABS

Number one in a fall series of 12 IMS legislative briefings will be September 28 in Oskaloosa. As with each session, the Oskaloosa meeting will bring legislators residing in that IMS district (VII) together with physician leaders to discuss upcoming issues. Any interested physician is welcome at his/her district meeting. October sessions are planned in Marshalltown (8th), Mt. Vernon (20th), Amana (21st), Guttenberg (22nd) and Mason City (26th). The series ends in mid-November. Contact IMS for more info.

NURSING MATTERS

The Iowa Board of Nursing has released proposed rules to give "Advanced Registered Nurse Practitioner" status to those qualified. The ARNP designation is planned initially (by meeting certain specific requirements) for the nurse anesthetist, nurse midwife and pediatric nurse practitioner. The IMS MD/RN Liaison Committee, chaired by L.F. Staples, M.D., Des Moines, is reviewing the proposed rules with appropriate medical specialty input. Discussion with the Board of Nursing is anticipated.

NEW IMS DIRECTORY

The 1981-82 IMS Member Directory will be distributed in October to all member physicians. A new dimension of the directory will be the entry of specialty designations.

BME INVESTIGATOR

Robert Olsen began work in August as a staff investigator for the Board of Medical Examiners. Olsen comes to the BME from the State Department of Health. One additional BME investigator position remains to be filled this fiscal year. Efforts have been pursued to gain the designation chief investigator for Mike Archibald, who's been with the BME since 1978.

DISCUSS UCR, EOB, ETC.

Blue Shield representatives met August 27 with the IMS Committee on Medical Service to discuss preliminarily possible new approaches to usual and customary fee determinations, to the "hold harmless" concept and to the handling of the explanation of benefits.

CONSIDER BLOCK GRANTS

The impact of federal block grants to the states will be considered further by IMS reps attending a September 19 and 20 AMA conference to examine the anticipated shift in health program responsibility to the state level.

BILL OF RIGHTS

The 1981 Iowa General Assembly passed legislation requiring that a bill of rights be applied to residents of any Iowa health care facility (nursing home) who are covered by Medicaid. The IMS was present August 17 at a meeting on this topic. The matter is likely to be acted on by the State Board of Health this month.

DRUG LIST EXPECTED

Word has come from the Iowa Board of Pharmacy that it expects to release in September what it calls a "negative drug formulary." This listing of approximately 65 drugs (mostly generic) is to be provided physicians and pharmacists. These medications have been demonstrated as non-equivalent and not interchangeable. The Board has been charged by statute to promulgate such a list.

1982 SCIENTIFIC SESSION

April 6, 7 and 8 are dates for the 1982 Iowa Medical Society Scientific Session. The Program Committee, chaired by Douglas Dorner, M.D., Des Moines, meets September 10 to begin planning.

BC/BS FISCAL PICTURE

Blue Shield had just over \$102 million in subscriber income the first six months of 1981; nearly \$98 million was paid in physician claims. Counting administrative expense, a slight deficit existed as of June 30. Blue Cross income for the like period was \$94.6 million, with \$91.8 million having been disbursed.

malpractice

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VOX DOCS

Please take a look at this month's Vox Docs question below. Then give us your answer. Send it to IMS JOURNAL, 1001 Grand Avenue, West Des Moines, Iowa 50265. Last month's question/answer results are shown to the right with several comments below.

"A careful office physical done every third year would be of much more value than examining a male in a gym annually." — G. F. Fieselmann, M.D., Spencer

"Because a 'good physical' is not logistically possible for every player, we end up doing less than a good px. Better to do one every third year and stagger, then a good one could be done." — J. F. Roules, M.D., Mediapolis

"I think they need a good exam every three years, but a physician validation should occur on the alternate years to review any injury or illness in the interval. This could be done expeditiously and inexpensively. Any new problem found at the validation check would, of course, be followed." — S. D. Porter, M.D., Mason City

"Those with heart murmurs or other heart diseases or other ailments need to be checked annually. Those who are healthy could be done every two or three years." — R. Y. Sembrano, M.D., Bloomfield.

LAST MONTH'S QUESTION —

How often should physical examinations for school athletics be required?

ANNUALLY	38%
COULD BE EVERY OTHER YEAR	24%
COULD BE EVERY THIRD YEAR	38%

"With the increased pressures placed on our young high school athletes, I feel annual physical examinations are an absolute must. They are placed under more physical and mental stress these days in competition." — Roger W. Boulden, M.D., Lenox

"Ideally, on annual basis provided exam is complete to include evaluation of musculoskeletal readiness to participate. This is especially true for football. The annual exam is also a good time for counseling by a sports oriented physician." — A. L. Jensen, M.D., Cedar Rapids

"The IMS Committee on Sports Medicine has recommended giving a complete and thorough exam every third year with a mini-checkup in the intervening years. I feel it necessary to see young athletes annually to review available information with them. There is too much chance of something occurring if we don't." — J. H. Spearing, M.D., Harlan

SEPTEMBER QUESTION FOR IOWA PHYSICIANS

If circumstances suggested the need, would you be inclined to arrange for a physician colleague encountering problems to be contacted for help through the Iowa Medical Society Assistance Program for Troubled Physicians?

- ☐ YES, I WOULD MAKE SUCH A CONTACT.
☐ NO, IT IS UNLIKELY I WOULD INITIATE SUCH A CONTACT.
☐ I DON'T KNOW.

Comment, please _____

Name _____

Address _____

(Please Complete and Send to IMS JOURNAL, 1001 Grand Avenue, West Des Moines, Iowa 50265)



QUESTIONS - ANSWERS

**NORMAN K.
RINDERKNECHT, M.D.**
Des Moines, Iowa

COMMENTS ON HYSTERECTOMY STUDY

The following observations are on the Iowa study of hysterectomy which appears in this issue. They are the individual thoughts and opinions of Dr. Rinderknecht, who is in the private practice of obstetrics and gynecology. Dr. Rinderknecht serves currently as chairman, Iowa section, American College of Obstetricians and Gynecologists.

The study of hysterectomies reported in this issue by the Iowa Foundation for Medical Care Committee on Continuing Medical Education indicates they are being done in Iowa for appropriate reasons. We assume you agree?

I accept this assumption with some reservations because 45 hospital committees noted more than 300 variations of 12 valid indications for hysterectomy. The credibility of the study in terms of the local data gathering and the analysis process is questioned by the IFMC Continuing Medical Education Committee. Included in the justified group were hysterectomies performed for treatment of pelvic relaxation, treatment of atypical cervical cytology without appropriate cervical biopsy, and some committees approved hysterectomy in lieu of dilatation and curettage. I find these "approved" indications for abdominal hysterectomy highly questionable and suggest that perhaps more than 5% of hysterectomies were performed without appropriate reasons.

Some observers have said this procedure is recommended too frequently by physicians. Do you think there is any validity to that?

Yes, there is some validity. Physicians vary a great deal in their attitude toward recommending hysterectomy. Some are very objective and use only well defined indications. Others are more subjective and will suggest hysterectomy, not only for the well-defined indications, but also for the "quality of life" indications without recognized pathology (i.e., pelvic inflammation, leiomyomata, endometriosis). It depends on the physician's training, personality, personal experience, peer pressure, the practice situation and the patient population to whom service is rendered. Physicians leaning toward the more objective, well-defined indications for hysterectomy will perform fewer procedures. Now, add the frequently found lack of adequate documentation to this difference in attitude regarding surgical indication and you have reasons why some observers feel hysterectomy is recommended too frequently by some physicians.

What about the so-called "quality of life" reason for a hysterectomy? Is it justified?

There are some situations where the "quality of life" reason for a hysterectomy may be justified. There are a small minority of patients who have severe symptoms (i.e., pelvic pain, unusual bleeding) without any objective physical, laboratory or pathologic findings who will derive great benefit from having a hysterectomy performed. However, this patient should have had rather prolonged evaluation prior to the surgery. A diagnostic laparoscopy and/or a dilatation and curettage may also be needed prior to suggesting a hysterectomy. Such patients are also ideal candidates for "second opinion" prior to performing definitive surgery. Such patients with "quality of life" indications should be the exception rather than the rule in any physician's practice.

Is there reasonable uniformity among individuals as to the reasons for recommending hysterectomy? Or is each case pretty distinct unto itself?

The reasons for recommending hys-
(Continued on page 381)

This is a continuing medical education presentation. It is based on a study of 1,616 abdominal hysterectomies in 45 Iowa hospitals. The basic conclusion is that hysterectomies are being performed in Iowa for appropriate reasons and with a high level of safety and expertise. Doing the procedure for "quality of life" indications still needs further evaluation.

At the conclusion of this discussion, you will find a special orange-colored one-page insert. This insert contains an 8-question quiz. You are invited to complete this quiz, remove it from the JOURNAL and mail it with \$3 (to cover administrative costs) to the Iowa Foundation for Medical Care. The quiz will be evaluated and returned to you with appropriate comments. If you complete it satisfactorily (scoring criteria of 75% or better) you will be granted one credit hour in Category I for the Physician's Recognition Award of the American Medical Association. This education project is a joint service of the Foundation, the University of Iowa College of Medicine and the Iowa Medical Society.

Study of Abdominal Hysterectomies in Iowa Hospitals

STANLEY W. GREENWALD, M.D.,

RICHARD M. CAPLAN, M.D.,

CHARLES E. DRISCOLL, M.D., and

JENNIFER I. COFER, M.A.

IN 1978 a statewide study of abdominal hysterectomy was conducted by the Continuing Medical Education Committee (CMEC) of the Iowa Foundation for Medical Care (IFMC). Its objectives were to assure that 1) abdominal hysterectomies are performed for appropriate reasons, and 2) there are no major adverse results from the hysterectomies. The audit period was from January to December, 1977, or the first 50 abdominal hysterectomies performed at any one hospital during that period. One thousand six hundred sixteen (1,616) patients from 45 hospitals were studied; 397 physicians were involved.

The physician authors are members of the Continuing Medical Education Committee of the Iowa Foundation for Medical Care. Special appreciation is also extended to the late W. C. Keettel, M.D., professor, Department of Obstetrics & Gynecology, University of Iowa; Robert Pfaff, M.D.; Ronald Reider, M.D.; Michael Richards, M.D.; Harold Van Hofwegen, M.D.; and George West, M.D.

Audit specifications were sent to each hospital delegated to perform IFMC medical care evaluation. The selected study participants used their respective medical care evaluation (MCE) committees to (1) perform the local analysis, (2) judge variations from each criterion as either justified or deficient, and (3) give reasons for each decision. The IFMC Continuing Medical Education Committee has collected and summarized this information and presents a summary of each criterion.

CRITERION No. 1: INDICATIONS FOR HYSTERECTOMY INCLUDED:

- a) *dysfunctional uterine bleeding associated with submucous leiomyoma*
- b) *recurrent bleeding not controlled by dilatation*

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and curettage and/or hormonal management

- c) *uterine leiomyoma the size of three month's gestation or larger*
- d) *rapid enlargement of leiomyoma in past six months*
- e) *severe dysplasia of cervix (carcinoma in situ) where future childbearing not desired*
- f) *carcinoma of endometrium – stage 1*
- g) *sarcoma of uterus*
- h) *cancer of ovary*
- i) *benign ovarian neoplasm where future childbearing was not desired*
- j) *severe atypical adenomatous hyperplasia of endometrium*
- k) *bilateral ovarian pathology requiring removal of both ovaries (endometriosis, recurrent pelvic inflammatory disease, ruptured tubo-ovarian abscess, and treatment of breast cancer)*
- l) *obstetrical indications (ruptured uterus, uncontrolled postpartum hemorrhage, placenta accreta).*

Of the 1,616 patients studied, there were 333

variations, and 79 (4.88%) were not justified according to local MCE committees. The most common justification for a variation was "heavy bleeding" or menorrhagia. No information on previous dilatation and curettage or failure of hormonal management was given. Other reasons for variations were given as recurrent pelvic inflammatory disease, bilateral or unilateral ovarian pathology, repeated dilatation and curettages, endometriosis, adenomyosis, and leiomyomata. This was disconcerting because these indications are well described in the criteria (*a through l*). Technically, any case that met a criterion should not have been called a variation. Such errors put into question the credibility of the local data gathering and analysis process.

The IFMC CMEC also had concern over some of the reasons local MCE committees used to justify abdominal hysterectomies. These included cystocele, rectocele, uterine prolapse, and stress incontinence. Present thinking can be summarized as follows: "Pelvic floor relaxations, including uterine prolapse, should be corrected by vaginal surgical procedures with repair of the pelvic diaphragm and the stretched or scarred uterine supporting structures. Vaginal hysterectomy, if not accompanied by proper plastic repair of uterine supports and perivaginal connective tissue, will not cure prolapse."¹ Hysterectomy was occasionally used in lieu of a diagnostic or therapeutic dilatation and curettage. This practice is highly questionable.

Finally, a major concern was evidenced in the performance of hysterectomies on patients with a Class 3 Pap smear and/or chronic cervicitis without further diagnostic tests. Buchsbaum, *et al*,² in an excellent discussion of abnormal Pap smear and its management, declares that diagnosis of cervical carcinoma cannot be based on "the Pap test." It requires tissue confirmation by histological examination of a biopsy. Preferably, the patient with an abnormal Pap smear should be examined by a colposcope which allows the physician to direct his biopsy to the most abnormal site on the cervix. In over 80% of cases a well performed colposcopically directed biopsy and endocervical curettage can eliminate the need for hospitalization and conization with its cost and risk.³

The reasons given by local MCE committees for non-justification were equally interesting.

Most commonly, lack of complete documentation was given as the reason for hysterectomy. In some hospitals, local MCE committees said a D & C would have been more appropriate. This contrasted with other committees which allowed a hysterectomy to be justified without a previous D & C.

The 12 indications in this criterion were believed by the IFMC CMEC to be relatively non-controversial. For example, in item b, a reason for the failure of hormonal management might include a contraindication to the use of hormones, such as hypertension or a history of thrombophlebitis. In contrast, an area of controversy lies in what are sometimes called "quality of life" indications. These include, for example, hysterectomy for permanent sterilization, cancerphobia, pelvic pain, dyspareunia, pelvic congestion, dysmenorrhea that is progressive, minor bleeding problems of a recurring nature, or the pre-menstrual tension syndrome. Pratt⁴ has called these "hysterectomies that relieve symptoms" as opposed to "hysterectomies that cure pathological lesions." It was precisely in this area that the CMEC felt it should not be proscriptive. Rather, local peer judgment should come into play. Wording of our criteria should have caused charts with these "quality of life" indications to come to the local MCE committee. At that time, the peer judgment could be expressed. From the standpoint of the statewide medical care evaluation process, we would learn how often these indications appear and in what proportion of hospitals they are considered appropriate.

Reasons offered to justify surgery produced some possible "quality of life" indications, but we could not be certain. Some MCE committees were definitely unwilling to justify surgery done for menstrual discomfort or sterilization or symptoms of pelvic pain and/or discomfort; others probably were willing to justify surgeries done for these reasons.

CRITERION No. 2: SUBTOTAL HYSTERECTOMY.

Subtotal hysterectomy is rarely indicated even though it was a concept pushed by leading teachers in obstetrics and gynecology for over 30 years. Johnson, *et al*⁵ stated in an analysis of 6,891 hysterectomies for benign disease "there seems to be little reason for continuing to perform an operation which is attended

with an equal risk and which is also attended with a chance of persistence of symptoms referable to the cervix and with the possibility of future malignant disease." However, exceptions may sometimes be justified. In our study, the results were gratifying. Only six of the 1,616 hysterectomies were subtotal, and all of those were believed to be justified. Reasons for justification included, "it was difficult to palpate the cervix, and since this was benign disease, persisting with removal of the cervix would endanger ureter and rectum unnecessarily;" "emergency procedures;" and "technical difficulty in surgery and excessive blood loss." These surgeons are to be commended.

It must be remembered that insurance carriers and peer review committees generally

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consider a subtotal hysterectomy to be antiquated and of limited benefit. Thus, quite often a claim for this service will be denied. If the claim included documentation as our cases did, it is likely to be accepted. Of course, the attending surgeon always has the right of appeal when a claim for subtotal hysterectomy is denied.

CRITERION No. 3: PATIENT DISCHARGED WITH INDWELLING URINARY CATHETER.

This criterion was placed in the audit to provide insight into genito-urinary tract injury. Eight of the 1,616 patients undergoing abdominal hysterectomy were discharged with indwelling catheter, all for reasons justified by local MCE committees. Reasons offered as justifications did suggest urinary tract injury. If this reflects all urinary tract injuries, the frequency would approach only 0.5%. This is excellent and reflects a high degree of skill on the part of the physicians involved.

CRITERION No. 4: SYSTEMIC ANTIBIOTICS ADMINISTERED.

Five hundred fifty-six (556) of the 1,616 received antibiotics, 200 (12%) instances were routine prophylaxis against infection. In 152 of the 556, the local MCE committee believed the use was not justified. This suggests controversy in about one-fourth of the instances. Originally, the IFMC CMEC believed antibiotics should be employed in this operation only for a complicating infection. Grossman, *et al*⁶ found in their study that patients undergoing abdominal hysterectomy had a slightly lower incidence of postoperative infections when given prophylactic antibiotics, but the trend was not statistically significant. Allen, *et al*,⁷ took an opposite view. This prospective

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double blind controlled study found the morbidity of those patients undergoing abdominal hysterectomy was 41% in a placebo group and 14.1% in the drug group. In their study, morbidity was defined as (a) a temperature of 101° on two measurements six hours apart, excluding the first 48 hours (postoperative), or (b) other clinical signs of obvious infection. It was of interest in the Allen study that the most experienced surgeons had the same rate of morbidity as the inexperienced surgeons. Hospital stay was significantly reduced for the drug treated group in this study. In fact, abdominal hysterectomy patients who received antibiotics prophylactically spent an average of six days less in the hospital than those given the placebo. Chodak and Plant⁸ reviewed the gynecological literature from 1960 through 1976, using very rigid criteria, and identified 11 studies that generated meaningful data, in their opinion, on the effectiveness of prophylactic systemic antibiotics. Nine of the 11 supported the use of systemic prophylactic anti-

biotics for patients undergoing Cesarean section, vaginal hysterectomy, or abdominal hysterectomy. Ledger *et al*⁹ offered the following guidelines for antibiotic prophylaxis in gynecology:

- 1) *The operation should carry a significant risk of postoperative site infection.*
- 2) *The operation should cause significant bacterial contamination.*
- 3) *The antibiotic used for prophylaxis should have laboratory evidence of effectiveness against some of the contaminating microorganisms.*
- 4) *The antibiotic should be present in the wound in effective concentrations at the time of incision.*
- 5) *A short-term, low toxicity regimen of antibiotics should be used.*
- 6) *Antibiotics needed to combat resistant infections should be reserved and not used for prophylaxis.*
- 7) *The benefits of prophylactic antibiotics must outweigh the dangers of antibiotic use.*

Appropriate antibiotic usage continues to be a confusing area. The savings on cost of antibiotics alone make this important. On the other hand, depending upon the choice of antibiotic used prophylactically, there may be savings by shortening hospital stays. The IFMC's Continuing Medical Education Committee strongly encourages both local and statewide educational efforts about proper use of antibiotics and recommends further investigation by audit of antibiotic use.

CRITERION No. 5: MORTALITY.

There was no mortality among the 1,616 patients having hysterectomies, and since they were performed by 396 physicians in the 45 hospitals, the data speak for the safety of this operation. Child, *et al*¹⁰ have analyzed data published by the Commission on Professional and Hospital Activities. They found hysterectomy is a common operation, estimating 678,000 performed each year in the United States. Of the major operations, only appendectomy is more frequent. Child, *et al*, found mortality per 10,000 patients to be 16.4, compared with appendectomy mortality per 10,000 patients of 37.9, and cholecystectomy, 141.7. These data also testify to the safety of the hysterectomy procedure, but say nothing about morbidity. The IFMC CMEC suggests that, in a repeat audit, a criterion be designed to study morbidity in greater detail.

CRITERION No. 6: LENGTH OF STAY.

- a) Preoperative maximum: one day.*
- b) Postoperative maximum: seven days, including day of surgery.*

The only exception allowed was to add one day if there were pre-existing complications and a defined plan for evaluation and stabilization.

Five hundred seventy (570) variations (35%) in length of stay were found, and 145 (8%) of these were believed not to be justified. More than 130 patients had need of a preoperative work-up which extended the total stay; 15 had complications preoperatively that required management prior to surgery. Audit committees thought 35 patients could have been discharged earlier. Twenty others lacked sufficient documentation of the reasons for keeping the patients longer than eight days.

The IFMC CMEC believes this criterion has great practical importance for the local hospital administration and medical staff in looking at bed utilization. Pre-admission testing has been slow to be accepted, but would obviously improve length of stay results. Much of the preoperative work-up could probably have been done on an outpatient basis.

CRITERION No. 7: TRANSFUSION.

Friedan¹¹ studied surgical blood use in United States hospitals and found 12.4% of all patients undergoing abdominal hysterectomy were transfused. They received a mean of 2.2 units of blood each; 8.2% of all patients undergoing abdominal hysterectomy received two or more units of blood.

In our audit, 102 patients (6%) received transfusions. Most of the reasons for justification described operative or postoperative bleeding. Ten others documented anemia as the reason, with a surprisingly low frequency of preoperative anemia. Twenty patients had inadequate documentation on their medical record to justify transfusion. Ten other patients were believed to have had unjustified transfusions. Based on clinical information, this means that only 3% of the patients receiving transfusions in the study may not have needed the blood. The frequency of transfusion in our audit (6%) is low and provides further evidence of the skill of Iowa physicians.

Since approximately 90% of the patients

undergoing hysterectomy never require blood transfusions, a preoperative type and screen (T & S) order is adequate. A type and screen order would mean to group, type, and do an antibody screen of the patient preoperatively. If blood is needed later for that patient, additional crossmatching would require about 30 minutes. From the perspective of hospital blood bank personnel, excessive crossmatching results in an increased incidence of outdating of blood and increased patient costs. Thus, the IFMC CMEC strongly recommends that each local utilization committee carefully scrutinize its performance in this area. These considerations indicate that in routine abdominal hysterectomy the need for a type and crossmatch

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order for two units is not justified; a type and screen order will suffice.

CRITERION No. 8: WOUND INFECTION.

CRITERION No. 9: FEBRILE POSTOPERATIVE COURSE.

CRITERION No. 10. OTHER SURGICAL COMPLICATIONS.

a) Operative incident, not part of the hysterectomy procedure, involving urinary tract, bowel, major vein or artery.

b) Second operation.

c) Readmission for second operation within six weeks of discharge.

Seventy-four (74) wound infections (4.6%) were reported, 60 which were judged as having been treated appropriately (justified) and 14 were judged deficient in care by the local committees. Reasons for the deficiencies were not explained. Two hundred and ten (210) patients (13%) had a febrile postoperative course, defined as a temperature greater than 101° F for

two consecutive days. National data from the PAS Reporter¹⁰ indicate a 31% rate for postoperative fever. Local audit committees justified all but 41 cases. All justifications were due to postoperative complications which the audit committees believed were managed acceptably. The 41 deficiencies resulted from a lack of documentation of proper treatment. The discrepancy between the number of patients with fever (210) and/or wound infections (74) and those receiving antibiotics (556) is disturbing. This area needs further scrutiny in future audits.

Sixty patients had surgical complications of a varied nature, none of which seem to merit further study and all seemed to have had documentation of satisfactory management. There

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were only three cases of wound dehiscence in the entire audit.

ADDITIONAL COMMENTS

The committee was concerned about the age distribution of patients having a hysterectomy, believing that hysterectomy in young women (i.e., under age 35) needed closer scrutiny. Unfortunately, the design of this study did not plan for that, and no meaningful data on the patient's age incidence was obtained. Future audits should be designed to correlate age with the indications.

The audit clearly showed marked deficiencies in adequate clinical notes. The deficiencies in documentation included indication for surgery, choice and use of antibiotics, reason for transfusion, and need for prolonged stay. Documentation of the complications and management plans often were not available, making the audit difficult to review. Good record keeping is a subject that needs constant reitera-

tion. Many hospitals are changing their bylaws to strengthen their requirements for record keeping while still guaranteeing due process for the attending physician. These efforts are to be applauded. A record that lacks documentation should be considered an incomplete record and returned to the physician. When it meets the hospital's criteria, then it may be filed as truly complete. Credential committees, medical record committees, and other medical staff committees must all work to improve hospital records and physician performance.

Overall, the audit suggests that hysterectomies are being performed in Iowa for appropriate reasons and with a high level of safety and expertise. "Quality of life" indications need further study and consideration. This indication has always existed, if not in the record, at least in the minds of the provider and consumer.¹² This indication should appear in the medical record with excellent documentation lending itself to scrutiny by peer review committees, tissue committees, utilization committees, insurance carriers, and consumer groups as well as provider groups. While this indication has not yet come of age, with documentation it could become a lasting "legitimate" indication.

Remember, the purpose of MCE studies is not to prove that providers of health care are flawless; it is to find problems and offer solutions. With this audit we have identified problems and now steps must be taken to correct them.

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STUDY OF ABDOMINAL HYSTERECTOMIES IN IOWA HOSPITALS

Continuing Medical Education Credit Quiz

This learning experience is intended for all health professionals performing or assisting in the performance of hysterectomies. When the learner completes this reading, he/she will be able to: (a) identify in his/her patients the appropriate surgical indications for abdominal hysterectomy; (b) state the next appropriate step in the diagnostic workup after discovery of a Class 3 Pap; (c) state the appropriate medical record order concerning the transfusion requirements of patients undergoing abdominal hysterectomy; (d) become aware of current medical practices in the care of pelvic floor relaxation, and in the use of prophylactic antibiotics.

One hour of continuing medical education credit (AMA Category I) is offered to those who read the article carefully and answer the questions. You are invited to answer the questions and submit them with the information requested. Simply (1) check the correct answers; (2) enter the information requested; (3) remove this page from the JOURNAL; (4) prepare a check for \$3 (to cover administrative costs) made payable to the University of Iowa; and (5) mail the quiz and check to the Iowa Foundation for Medical Care, Colony Park Suite 500, 3737 Woodland Avenue, West Des Moines, Iowa 50265. You will be provided a report on your quiz and a confirmation of the CME credit.

As an organization accredited for continuing medical education, The University of Iowa College of Medicine designates this continuing medical education activity as meeting the criteria for one credit hour in Category I for education materials for the Physician's Recognition Award of the American Medical Association provided it has been completed according to the instructions.

PLEASE ANSWER THE FOLLOWING QUESTIONS (choose the one best answer)

1. Problems of pelvic floor relaxation including uterine prolapse are:

- ☐ a. an indication for abdominal hysterectomy
- ☐ b. best corrected by simple vaginal hysterectomy
- ☐ c. accompanied by stress incontinence in virtually 100% of cases
- ☐ d. not corrected without proper plastic repair of uterine supports

2. A Class 3 Pap smear:

- ☐ a. is sufficient evidence for the diagnosis of cervical carcinoma in situ
- ☐ b. is accepted as an indication to perform abdominal hysterectomy
- ☐ c. mandates subsequent histological confirmation by directed biopsy
- ☐ d. should be investigated by hospitalization and conization before hysterectomy

3. Concerning prophylactic antibiotics in abdominal hysterectomy, the consensus of the literature reviewed was:

- ☐ a. the more experienced the surgeon, the lower the morbidity
 - ☐ b. in favor of local or topical antibiotic prophylaxis in the vagina
 - ☐ c. the placebo treated groups do as well or better than drug treated groups
 - ☐ d. that this continues to be a confusing area
-

-
4. In considering transfusion requirements for patients undergoing abdominal hysterectomy:
- ☐ a. o type and crossmatch for two units of blood is needed
 - ☐ b. o type and screen order preoperatively is adequate
 - ☐ c. a type and cross match for only one unit of blood is adequate
 - ☐ d. transfusion is never needed if surgery is properly performed
5. The most frequent justification that Iowa physicians used for performing an abdominal hysterectomy when specified indications for surgery were *not* met was:
- ☐ a. pelvic floor relaxation
 - ☐ b. menorrhagia or "heavy bleeding"
 - ☐ c. chronic cervicitis/Class 3 Pap smear
 - ☐ d. recurrent pelvic inflammatory disease
6. A reoccurring and disconcerting finding of the IFMC shared studies is:
- ☐ a. the apparent high numbers of nonjustified surgical procedures
 - ☐ b. the apparent misuse of audit data for utilization review purposes
 - ☐ c. the apparent misunderstanding and misuse of the terms "variation" and "justified"
 - ☐ d. the apparent lack of high quality medical care
7. Subtotal hysterectomy is a surgical procedure
- ☐ a. that is antiquated but on rare occasions may be the procedure of choice
 - ☐ b. recommended for general practitioners
 - ☐ c. associated with less surgical and long term risk than total abdominal hysterectomy
 - ☐ d. most recently found to be most appropriate for pelvic relaxation
8. Patients discharged from the hospital after abdominal hysterectomy who left with a Foley catheter in place probably:
- ☐ a. had pelvic floor relaxation syndrome
 - ☐ b. were overtreated with narcotic analgesics
 - ☐ c. should have had a vaginal hysterectomy procedure
 - ☐ d. suffered urinary tract injury during surgery

PLEASE DO THE FOLLOWING IN ORDER TO RECEIVE CREDIT:

1. Be sure your answers are indicated in the boxes provided.
2. Remove this page from the JOURNAL.
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Ethical Dilemmas In Transplantation

JOHN C. WEST, M.D., and
ROBERT J. CORRY, M.D.

THE STANDARDS OF CONDUCT and moral judgment — *the ethics* — of medical personnel as they relate to the use of borrowed organs — artificial or transplanted — involve an inquiry into the balance of social needs and individual rights.

The Greeks recognized three faces of medicine — PANACEA (the Goddess of healing or clinical medicine); HYGEIA (the Goddess of good health, public health, or preventive medicine), and the DOGMATISTS (who held that medicine should be a science resembling geometry and therefore were skeptical of the clinicians — EMPIRICI — who simply treated the sick according to their experience). Each physician can decide into which category he/she falls but none of us can deny our moral obligations to respond to the social needs of society and to respect a person's individual rights — with the common goal of preserving the well-being of our species. Historically, most people, most of the time, experience their first serious illness in infancy before acquisition of speech. More recently, such serious illness within the first 30 years of life has become less frequent. This has encouraged us to define the so-called "SICK ROLE" as elucidated by Talcott Parsons from Harvard, the so-called "PARSONS' POSTULATES."

Dr. West was an assistant professor, Division of Transplantation, Department of Surgery, University of Iowa College of Medicine, when this paper was prepared. He is now director of transplantation, Geisinger Medical Center, Danville, Pennsylvania. Dr. Corry is a professor and director of the U. of I. Transplantation Service.

The authors present thoughts on the philosophically provocative topic of human organ transfer. They speak from the "leading edge of acceptable current medical techniques" as transplant surgeons. They assume the risk of probing beyond the acceptable.

PARSONS' POSTULATES

1. *The sick person is exempted from some or all of his normal responsibilities.*
2. *The sick person cannot help being ill and cannot get well by an act of decision or will.*
3. *The sick person is expected to want to get well as soon as possible.*
4. *He is expected to seek appropriate help and cooperate with that help in an effort to get well.*

Diseased organs often cannot recover and if they are essential to an individual's biological and human personal life, they must be removed and/or replaced. In spite of the fact that artificial organs are meeting with increasing success, it is obvious that healthy living tissue is the best substitute.

Transplantation of human organs and tissues requires that surgeons act pursuant to applicable standards of care, obtain requisite "informed consent," and carefully observe all legal requirements. In so doing, the surgeon must recognize and apply what Peterson has termed his *Aesculapian Authority*. The transplant surgeon will identify the requisites of society and the role of the sick individual, and also delineate their common points. By *Aesculapian authority*, I am referring to *Sapiential Authority* (advise, inform, instruct, direct, but

THE IOWA MEDICAL FOUNDATION HAS DESIGNATED THIS ARTICLE AS THE HENRY ALBERT
SCIENTIFIC PRESENTATION FOR THE MONTH OF SEPTEMBER 1981

NOT order), *Moral Authority* (the rightness and goodness according to Ethos of enterprise), and *Charismatic Authority* (control and direct).

The sick role, Aesculapian authority, and societal needs converge upon the patient's admission for transplantation — all are the culmination of an orderly evolution of therapy (adequate animal research, immunosuppression experience, and protocol for followup evaluation and treatment), examination of legal aspects, and public awareness. Problems arise when the following occur:

Vituperative, emotive commentaries involving such phrases as "Cannibalizing" or "Human Vivisection."

Failure of the procedure to measure up to its expectations.

The ease with which the lay press may raise those expectations.

The necessity (early on) to choose among patients as to which life to prolong.

The risk to the donor (be it cadaveric or living related).

The degree to which society should invest public funds in expensive procedures to prolong for an uncertain period the lives of relatively few people with otherwise fatal illness (?).

The limitations (financial, facility, complications) to the use of artificial or transplanted organs.

Professional and lay interest in transplantation has seldom been equalled by any new development in medicine. As such, interest became focused upon the religious and legal aspects of such procedures, particularly with regard to organ donation.

If God commissioned man to have dominion over the earth and things of nature (the argument goes), did He also give man the right of organ disposal or does this constitute unfounded interference? Man is not the absolute master of his body, since existence is a God-given gift, and therefore transplantation would constitute "unfounded interference." But what of the concept of TOTALITY, that the good of the part is subordinate to the whole? On this premise, in the interest of the whole, man may dispose of his parts (physical and/or psychical, diseased and/or normal). It is of remarkable interest (perhaps perspicacity!) that the participants of the VIIth International Congress of the Transplant Society, held in Rome, had an audience with Pope John I whose words to them of "Congratulations" and "Trust," advised them to "act with respect for

the person and for one's neighbors, whether it is a question of donor of organs or beneficiaries, and never to transform man into an object of experiment. . . . We pray to God, the Author of life, to inspire you and assist you in these magnificent and formidable responsibilities" (Rome, Vatican, September 6, 1978).

Legal precepts also evolved in an area which had hitherto been without precedent. Few litigations to date in the field of transplantation are thought due to:

1. *Absence of precedents;*
2. *Low expectations for success (initially);*
3. *Careful personal relationship between the doctor and the patient (family meetings, multiple prior access procedures, and so forth).*

The UNIFORM ANATOMIC GIFT ACT (1968) as developed by the Sadler brothers made it legal for any competent adult to authorize a gift of any or all bodily parts, to take effect at death. This also applied to relatives in order of kinship. This law gave the transplant surgeon immunity for handling the mechanics of giving and receiving of anatomical gifts and assumes the doctor acted in good faith in his decision as to the timing of death.

Black's Law Dictionary defines death as "cessation of life, ceasing to exist; . . . total stoppage of the circulation of the blood and the cessation of the animal and vital functions consequent thereupon. . . ."

The Harvard Medical School *ad hoc* Committee added:

1. *Unresponsiveness to external stimuli three minutes off the respirator;*
2. *No spontaneous movement or breathing;*
3. *No reflexes;*
4. *Flat EEGs.*

The American Bar Association holds that "the human body with irreversible cessation of total brain function, according to the usual and customary standards of medical practice, shall be considered dead."

The legal concept of "informed consent" continues in its evolution as a "reasoned, intellectual decision." Some psychiatrists have labeled "informed consent" as it relates to the kidney donor a "myth," based on the fact that many/most donors make an immediate (? rational) decision. This is justified on the grounds that MORAL DECISION-MAKING can be immediate since the potential donor has all data available immediately to make his deci-

sion (awareness of consequences, ascription of responsibility, and moral norms).

The courts have authorized donations from minors (Massachusetts, 1957, identical twins, "not donating would have grave emotional impact on survival") and incompetents (Strunk vs Strunk, 1969, doctrine of SUBSTITUTED JUDGMENT: the court must "substitute itself as nearly as may be for the incompetent and act upon the same motives and consideration as would have moved the incompetent").

The transplant surgeon operates on a leading edge of acceptable current medical techniques and, in so doing, risks probing beyond the acceptable. He acts at his own peril but can control his own risk by operating from a medically-justifiable rationale held by a sufficient number of physicians.

Hopefully we are not approaching the philosophical point where one might ask the question: "Are we moving in the name of science and mercy toward a nightmare world in which a segment of our (least fit) population is kept alive by being hooked up to ingenious machines operated by the other (more fit) half?" If man is to be really "cannibalized,"

does the ancient question of the seat of the soul or of the self cease to be academic? What, then, of Descartes' famous dictum, "*Cogito ergo sum*"? Who then, will be "I"?

In closing, let me quote a poem John Owen noted in *Epigrams* (1620):

*God and the doctor, we alike adore,
But only when in danger, not before,
The danger o'er, both are alike requited,
God is forgotten and the Doctor slighted.*

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QUESTIONS/ANSWERS

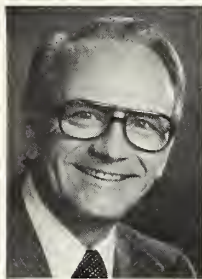
(Continued from page 372)

terectomy were referred to in previous answers. Indeed, each particular patient is distinctly different and poses various diagnostic and therapeutic challenges. I do not mean to categorize all patients into either those with well-defined indications and objective findings or those with "quality of life" indications. Many patients have a combination of symptoms, findings and personal and medical history which prompts the physician's recommendation. The physician may recommend medical management, surgical treatment or reassurance without further treatment.

Perhaps more emphasis should be given to the latter.

Documentation was cited as an area needing constant attention, not only for hysterectomies, but across the spectrum. Care to comment?

My experience with medical record, peer review and medico-legal committees causes me to believe that lack of adequate documentation can frequently precipitate a critical evaluation of a physician's performance. A complete record of previous attempts at medical management, diagnostic activity, laboratory results and physical findings will usually explain actions taken to the satisfaction of all concerned. This documentation concern was nicely addressed in the study. More important than peer review or medical record committee needs is the fact that adequate documentation also contributes to better quality patient care.



COMMENTING EDITORIALLY

MARION E. ALBERTS, M.D.
SCIENTIFIC EDITOR

HYSTERECTOMY STUDY

ANOTHER opportunity is provided in this issue of the JOURNAL to obtain CME credit. A study of abdominal hysterectomies in Iowa hospitals provides an overview of the

PRE-OPERATIVE CHEST X-RAYS UNNECESSARY

AREPORT in the April *Pediatrics** discourages the taking of a chest X-ray in the preparation for elective surgery on children. The authors conclude these routine procedures should be stopped due to the low yield of significant information. Further, they believe the same should hold true for routine chest X-rays on children admitted to a hospital for reasons other than surgery. They line up also against the so-called screening X-rays for young people, e.g., the pre-college examination.

Their study of 1,924 patients included 749

* Wood, R. A. and Hoekelman, R. A.: Value of chest X-ray as screening test for elective surgery in children. *Pediat.* 67:447-452, 1981.

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subject and its many ramifications. Then, by completing a short quiz, submitting it for verification, and eureka — CME credit.

The questions in the quiz will stimulate thoughts about the indications for abdominal hysterectomies, and the numerous considerations relative to the surgery and the after-care of the patient. Questions raised in the study have to do with advisability of prophylactic antibiotics, transfusion requirements, and postoperative care as well as pre-operative considerations.

Apart from the study by the Continuing Medical Education Committee of the Iowa Foundation for Medical Care, the reader is also urged to read Dr. Rinderknecht's comments in the Questions/Answers section. We are happy to provide to our readers another opportunity to "learn and earn" one credit hour (AMA Category I) — M.E.A.

(39%) who had preoperative chest X-rays and 1,175 (61%) who did not. Only 35 previously unknown conditions were found in the 749 children, and of these 9 (1.2%) were considered significant, and only 3 (0.4%) were sufficient to postpone or cancel the proposed surgery.

The lack of the preoperative chest X-ray was found to be an insignificant factor in the development of a post-operative complication. The most common postoperative complaint of an elevated body temperature was noted in 22 of all patients studied, and 17 of these had normal chest X-rays. (The other 5 did not have a chest X-ray.)

Furthermore, 12 of 21 patients readmitted after surgery with a directly related complaint had completely normal pre-operative test results, including the chest X-ray. The other 9 cases involved bleeding after surgery. There were no differences in anesthesia or post-operative complications in the two groups.

The low yield of significant information from the chest X-rays, as well as cost and possible radiation hazard, make it seem wise to conclude that routine chest X-rays need not be done except on an individual basis. Emphasis should be placed on a complete history and physical examination; this appears to be the most valuable and effective element in the process. — M.E.A.

A MAN TO REMEMBER!

THE IMS JOURNAL is pleased to print a statement from the Wright County Medical Society in honor of Charles P. Hawkins, M.D., Clarion, who died June 26.

Dr. Hawkins had friends and admirers throughout Iowa. Many became friends through his long participation in the IMS House of Delegates and his service (including the presidency) to the Iowa Academy of Family Physicians.

Indeed, Dr. Hawkins was an articulate, forthright and courageous spokesman for his beliefs, and the general principles and philosophies of the medical profession.

He "won a few" and "lost a few" arguments on the floor of the House of Delegates, where he served long and well. In doing so, he was

always stimulating, presenting his ideas with grace and humor.

The IMS JOURNAL joins the Wright County Medical Society in saluting a good friend and colleague by noting the action of the WCMS:

At the monthly meeting of the Wright County Medical Society on July 21st at Belmond, Iowa, the members wish to recognize, with pride, the contributions which our late-member, Charles P. Hawkins, M.D., gave to our profession. Dr. Hawkins shared his knowledge and wisdom with the Iowa Medical Society, the AMA, and County Society, having served as past-president, delegate, and many years as secretary-treasurer. He was a charter member of the American Academy of Family Practice and served as president of Blue Shield of Iowa.

Dr. Hawkins, having called himself "The Old Country Doc," will be greatly missed by his community, his professional partners, and his family and friends.

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DRUG THERAPY REVIEW



UNIVERSITY OF IOWA HOSPITALS AND CLINICS

REYNOLD SPECTOR, M.D., Editor

POSTLUMBAR PUNCTURE HEADACHE: PREVENTION AND TREATMENT

POSTLUMBAR PUNCTURE HEADACHE (PLPH) is a relatively common complication after entry into the subarachnoid space and is frequently a distressing clinical problem. Dural puncture and entry into the subarachnoid space occurs during the diagnostic and therapeutic removal of cerebrospinal fluid, the radiographic procedure of myelography, and the administration of spinal anesthesia and may inadvertently occur during epidural anesthesia. The incidence of PLPH reported from various patient series ranges from 0.5 to 60%.¹ The headache usually occurs between the first and the third day postlumbar puncture, lasts for several more days, but occasionally persists for weeks to months.² The quality of PLPH ranges from mild to severe and characteristically worsens when the patient assumes the upright posture. Cranial nerve disturbances may rarely complicate PLPH.²

This information for Iowa physicians is furnished and sponsored by the University of Iowa Hospitals and Clinics.

There are several techniques which have proved helpful in the prevention of PLPH including the use of a smaller gauge spinal needle, the administration of intravenous fluids, and the prone positioning of the patient postlumbar puncture. In a large retrospective study of obstetric patients receiving spinal anesthesia, the total incidence and relative severity of headache following the use of the smaller (25 gauge) spinal needle was less than one-half that following the use of larger (24 or 22 gauge) spinal needles.³ The routine use of a 25-gauge spinal needle may present difficulties in the performance of successful lumbar puncture; however, the principle of employing the smallest gauge spinal needle with which the operator feels confident is reasonable in attempting to prevent PLPH. In another study of obstetric patients receiving spinal anesthesia, the infusion of 500 milliliters of normal saline immediately following delivery in one group resulted in a greater than 50% decrease in the incidence of PLPH compared with a group of patient controls who received no intravenous infusions.⁴ Finally, in a nonrandomized study of 894 patients who, after lumbar puncture were instructed to lie on their abdomens (prone positioning) for three hours prior to ambulation, PLPH occurred in only four patients ($\approx 0.5\%$); 200 other patients were similarly treated with the exception of supine positioning and developed PLPH with an incidence of 36.5%.⁵

There are several other therapeutic modalities which have been used in the treatment of PLPH. Studies have examined both the success rate of these therapies and their complications. It should be remembered that PLPH is an uncomfortable but generally benign process. Therefore, its routine treatment should not place the patient at risk for the development of even more serious complications.

Caffeine sodium benzoate (CSB) has been found to be effective in the treatment of PLPH without risk of any significant adverse effects. In a prospective randomized double-blind study of patients with postspinal anesthesia headache,⁶ the intravenous injection of CSB (500 mg/2 ml) resulted in relief of PLPH in 15 of 20 patients (75%) whereas the control group treated with intravenous saline obtained relief in 3 of 21 patients (14%). The statistical difference was highly significant ($p < 0.0001$). Of the 5 patients who failed to obtain headache relief

with the initial dose of CSB and demanded additional medication one to two hours later, a repeat dose of CSB provided relief in 2 additional patients for a combined effective percentage of 85% (17/20). The authors⁶ suggest that intravenous CSB may be repeated at eight-hour intervals if necessary. However, more than 3 injections were rarely needed. The only untoward effects of CSB noted were momentary dizziness or a flushed feeling.⁶

PLPH has also been treated by the epidural injection of saline or autologous blood (epidural blood patch).⁷ However, although frequently effective, epidural blood patches are not without complications. For example, there is a reported case of a patient who developed severe back and radicular lumbosacral pain 2 to 3 hours after an epidural blood patch for PLPH.⁸ In my opinion, in view of the ease of administration, efficacy and safety, CSB should be tried first for PLPH and an epidural blood patch should be considered only if CSB is ineffective.

In summary, the incidence and severity of PLPH can be minimized by the use of a smaller gauge spinal needle, the maintenance of adequate patient hydration, and the prone positioning of patients postlumbar puncture. If PLPH occurs, it can be effectively and safely relieved in most cases by the slow intravenous administration of caffeine sodium benzoate in patients in whom caffeine is not contraindicated.⁹ Caffeine sodium benzoate is available in the pharmacy for this use. — Mark J. Goldberg, M.D., Instructor in Medicine and Pharmacology, University of Iowa Hospitals and Clinics.

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*Data on file Parke-Davis Marketing Research Dept.
**Based on total prescriptions filled for hemorrhoidal
preparations during the first three quarters of 1980.
The National Prescription Audit, IMS America Ltd.,
September 1980.

TUCKS® Pre-Moistened Hemorrhoidal/Vaginal Pads

Hemorrhoids and other anorectal uses—TUCKS extra-soft cloth pads allow for the gentlest possible application to tender, inflamed, hemorrhoidal tissue. TUCKS are effective cleansing pads for everyday personal hygiene. Used on outer rectal areas, they remove residue that can bring on more irritation. Pads are premoistened with 50% witchhazel, 10% glycerin USP and de-ionized purified water USP which acts as a cooling, soothing lotion to help comfort sensitive anorectal tissue.

Vaginal Uses—Comforting as an adjunct in postoperative care after episiotomies and other vaginal surgery or when relief from vaginal itching, burning or irritation is required.

ANUSOL-HC® SUPPOSITORIES

Hemorrhoidal Suppositories with Hydrocortisone Acetate
ANUSOL-HC® CREAM

Rectal Cream with Hydrocortisone Acetate

Caution: Federal law prohibits dispensing without prescription.

Description: Each Anusol-HC Suppository contains hydrocortisone acetate, 10.0 mg; bismuth subgallate, 2.25%; bismuth resorcin compound, 1.75%; benzyl benzoate, 1.2%; Peruvian balsam, 1.8%; zinc oxide, 11.0%; also contains the following inactive ingredients: dibasic calcium phosphate, and certified coloring in a hydrogenated vegetable oil base.

Each gram of Anusol-HC Cream contains hydrocortisone acetate, 5.0 mg; bismuth subgallate, 22.5 mg; bismuth resorcin compound, 17.5 mg; benzyl benzoate, 12.0 mg; Peruvian balsam, 18.0 mg; zinc oxide, 110.0 mg; also contains the following inactive ingredients: propylene glycol, propylparaben, methylparaben, polysorbate 60 and sorbitan monostearate in a water-miscible base of mineral oil, glyceryl stearate and water.

Anusol-HC Suppositories and Anusol-HC Cream help to relieve pain, itching and discomfort arising from irritated anorectal tissues. These preparations have a soothing, lubricant action on mucous membranes, and the antiinflammatory action of hydrocortisone acetate in Anusol-HC helps to reduce hyperemia and swelling.

The hydrocortisone acetate in Anusol-HC is primarily effective because of its antiinflammatory, antipruritic and vasoconstrictive actions.

Indications and Usage: Anusol-HC Suppositories and Anusol-HC Cream are adjunctive therapy for the symptomatic relief of pain, itching and discomfort in: external and internal hemorrhoids, proctitis, papillitis, cryptitis, anal fissures, incomplete fistulas, pruritus ani and relief of local pain and discomfort following anorectal surgery.

Anusol-HC is especially indicated when inflammation is present. After acute symptoms subside, most patients can be maintained on regular Anusol-HC Suppositories or Ointment.

Contraindications: Anusol-HC Suppositories and Anusol-HC Cream are contraindicated in those patients with a history of hypersensitivity to any of the components of the preparations.

Warnings: The safe use of topical steroids during pregnancy has not been fully established. Therefore, during pregnancy, they should not be used unnecessarily on extensive areas, in large amounts or for prolonged periods of time.

Precautions: General: Symptomatic relief should not delay definitive diagnoses or treatment.

Prolonged or excessive use of corticosteroids might produce systemic effects.

If irritation develops, Anusol-HC Suppositories and Anusol-HC Cream should be discontinued and appropriate therapy instituted.

In the presence of an infection the use of an appropriate antifungal or antibacterial agent should be instituted. If a favorable response does not occur promptly, the corticosteroid should be discontinued until the infection has been adequately controlled.

Anusol-HC is not for ophthalmic use.

Pregnancy

See "WARNINGS"

Pediatric Use

Care should be taken when using the corticosteroid hydrocortisone acetate in children and infants.

Dosage and Administration: Anusol-HC Suppositories—

Adults: Remove foil wrapper and insert suppository into the anus. Insert one suppository in the morning and one at bedtime for 3 to 6 days or until inflammation subsides. Then maintain comfort with regular Anusol Suppositories.

Anusol-HC Cream—Adults: After gentle bathing and drying of the anal area, remove tube cap and apply to the exterior surface and gently rub in. For internal use, attach the plastic applicator and insert into the anus by applying gentle continuous pressure. Then squeeze the tube to deliver medication. Cream should be applied 3 or 4 times a day for 3 to 6 days until inflammation subsides. Then maintain comfort with regular Anusol Ointment.

NOTE: If staining from either of the above products occurs, the stain may be removed from fabric by hand or machine washing with household detergent.

How Supplied: Anusol-HC Suppositories—boxes of 12

(N 0071-1089-07) and boxes of 24 (N 0071-1089-13) in silver foil strips with Anusol-HC printed in black.

Anusol-HC Cream—one-ounce tube (N 0071-3090-13) with plastic applicator.

Store between 59°-86°F (15°-30°C).

1089G010

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NEWS/PRODUCTS, PROGRAMS, ETC.

Information on various products, programs, etc., is received regularly by the IMS JOURNAL. Here are short items sifted from the mail by the Scientific Editor. A reference to a specific product is not intended to suggest any particular endorsement. Additional information on any entry may be obtained by contacting the IMS JOURNAL.

NEW LOOK — Macrochantin® capsules will have a new appearance according to Norwich-Eaton Pharmaceuticals. The capsules will be the same sizes and colors, and in addition the name of the drug and the dosage (25 mg, 50 mg, or 100 mg) will be imprinted. Also, the National Drug Code (NDC) number for each dosage size will be on the capsule. Patients should be informed of these changes to avoid confusion.

SEND FOR FREE COPY — ATHEROSCLEROSIS and ATHEROSCLEROSIS UPDATE: EMPHASIS ON DIET are two comprehensive publications produced by Best Foods. They may be obtained, free of charge, individually or in bulk (up to 70 copies), for health professional education programs. Write Best Foods Nutrition Information Service, Box 307, Department MSL-A, Coventry, Connecticut 06238.

OPINIONS RE ETHICS — A new edition of the AMA publication, *Current Opinions of the Judicial Council of the American Medical Association, 1981*, is available. It contains the revised Principles of Medical Ethics adopted by the AMA House of Delegates in 1980. It supercedes all earlier publications of the Judicial Council. Opinions appear on such diverse subjects as fees, informed consent, caring for defective infants, and coping with terminal illness. Requests for the booklet should be directed to Order Department OP-122, American Medical Association, P. O. Box 821, Monroe, Wisconsin, 53566. Single copies are \$4.

IMPROVING MEDICAL PRACTICE — A complete listing of AMA publications on improving medical practice management is now available. Publications are available on such topics as office design, professional corporations and patient relations. Educational aids for medical assistants are also offered. Contact the Department of Practice Management, AMA Headquarters, 535 North Dearborn Street, Chicago, Illinois 60610.

FREE AMA OFFER — Complimentary copies of the revised version of the *Quick Guide to AMA Services* are available. The Guide is based on requests most frequently received by the AMA and is categorized by subject. Contact the Office of Medical Society Relations, AMA Headquarters, 535 North Dearborn Street, Chicago, Illinois 60610.

SOME NEW BOOKS:

BASIC AND CLINICAL IMMUNOLOGY, 1980, 3rd Edition, by H. H. Fudenberg, D. P. Stites, J. L. Caldwell, and J. V. Wells. Lange Medical Publications, Los Altos, California. Price, \$17.50.

CURRENT OBSTETRIC AND GYNECOLOGIC DIAGNOSIS AND TREATMENT, 1980, 3rd Edition, by Ralph C. Benson. Lange Medical Publications, Los Altos, California. Price, \$21.00.

Remen, Naomi, 1980, **THE HUMAN PATIENT**, Anchor Press/Doubleday, New York, \$10.95. A provocative work on human nature and healing.

Freudenberger, Herbert J., 1980, **BURNOUT: THE HIGH COST OF HIGH ACHIEVEMENT**. Anchor Press/Doubleday, New York, \$9.95.

Janov, Arthur, 1980, **PRISONERS OF PAIN**, Anchor Press/Doubleday, New York, \$11.95.

Seaman, Barbara, 1980, **THE DOCTOR'S CASE AGAINST THE PILL**, Dolphin/Doubleday, New York, \$6.50.

Thompson, Douglass S., Consulting Editor, 1981, **EVERY WOMAN'S HEALTH: A Complete Guide to Body and Mind**, Doubleday, New York, \$19.95.

Conry, Tom, 1980, **CONSUMER'S GUIDE TO COSMETICS**, Anchor Press/Doubleday, New York, \$3.95.

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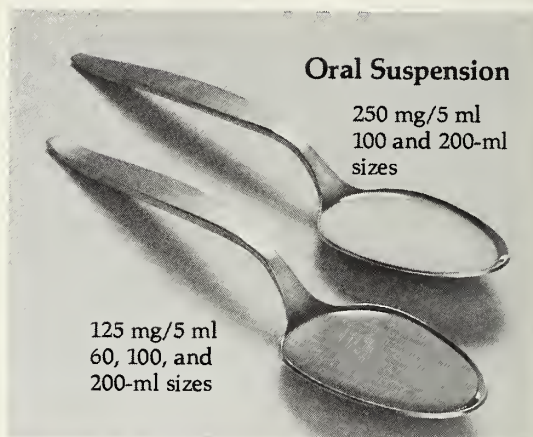
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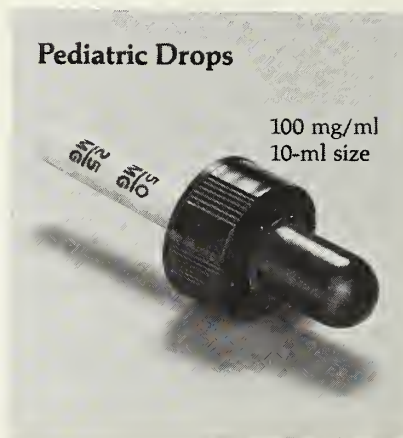
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OUR MAN ON EDUCATION

RICHARD M. CAPLAN, M.D.

GLOWWORMS AND CME

I'D LIKE TO TELL of my recent visit to the Waitomo Cave in New Zealand, where one may see a fascinating example of how nature — evolution, if you prefer — adapts biological behavior to local environmental circumstances. Then I will relate it to some thoughts about continuing education. (If I had the proper talent, I might tell this story via the classical 14-line Italian sonnet in which the first eight lines offer a description and the final six draw an analogy or make a specific application of the image evoked in the opening lines. Admission to medical school, it seems, doesn't select well for sonnet-writing skill, although it did so supremely at least once, in the case of John Keats.)

The limestone cave in question was formed by the erosive passage through it of the Waitomo River, containing in its water the larvae of certain mosquitoes, midges and flies, some of which hatch and leave the water while it courses within the cave. Waiting for these flying insects, then, are the "glowworms," actually the larvae of another kind of fly that inhabits the cave for about two days, just long enough to mate and lay eggs before dying for want of food. The female attaches a cluster of about 20 eggs to the cave ceiling. The first larva to hatch devours the remainder, thus providing the crucial first meal to fuel the tiny luminescent posterior organ. That meal also

allows the larva to construct a mucoid tube around itself on the ceiling where it lives, and from the surface of which it forms thin filaments that hang down several inches. When a flying insect, seeking the tiny glowing light, touches such a thread, it becomes trapped and numbed by the sticky surface-coating of oxalic acid. The larva then eats the thread with its attached victim.

After nine months of forming threads and capturing prey, the glowworm enters the pupa phase. Its surface becomes hard. No more is there any feeding nor growth in bulk. But growth, that is, a change of an incredible sort, continues within the husk to yield a complex adult with wings to fly and the apparatus for reproducing the next generation, but ironically, no mouth parts. Sex and reproduction have replaced eating and nourishment.

"If you have read this far I have you dangling from one of my filaments and can at least challenge you now to reflect on the subject in your own way."

What parallel can be drawn? That sex must be preceded by food? That's not what I had in mind. But in the domain of human development and learning, some argue for the insect-like model, in which one acquires more and more information, growing greatly to reach a stage in which the raw material is processed and transformed for the glorious stage of adult life in which knowledge finds its application. The analogy breaks down, though, when one attempts such a strict separation of the "larval" stage of acquisition of information and skill and the "pupa" stage of adding no more. Continuing Medical Education needs to be a constant taking-in along with processing and applying. That model parallels better the human, who can be larval (taking-in), pupal (processing) and adult (doing) simultaneously through most of its life span.

Maybe you don't care for my analogy. You'd probably have liked it even less if I'd attempted it as a sonnet. Think of it as you wish or interpret the matter otherwise. But if you've read this far, I have you dangling from one of my filaments and can at least challenge you now to reflect on the subject in your own way.

Dr. Caplan is Associate Dean for Continuing Medical Education at The University of Iowa College of Medicine.

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STATE DEPARTMENT/ PUBLIC HEALTH

NURSING HOMES BELONG TO THE COMMUNITY

FREQUENTLY WE FAIL to realize what we have until we lose it. This is true of communities that have "their community nursing home" threatened by closure. This interesting phenomenon emerges when the State Department of Health comes across atrocious conditions in a nursing home. When the Department indicates a license revocation may be necessary members of the community are almost certain to protest any such recommended action. Not until they are faced with the possible loss of a community asset do they realize it *belongs to them* and its closure will be of significance.

The health planning process under the Certificate of Need law has resulted in "franchised nursing homes." Bed need formulas call for a 95% occupancy. Some areas of the state have been successful in holding the number of available beds at that level. A 95% occupancy is equal to 100% when one considers the necessary down-time between occupants of a bed. This has resulted in virtual elimination of the free market. The purchaser of nursing home care in many areas of the state has no choice if close-by care is needed. In some counties there is only one nursing home. This competition for business that normally takes place among merchants and providers of service is limited in its presence.

A further reason nursing homes belong to the community is that half of all long term care is paid for by the government. The taxpayers are the biggest customers of all.

Irving Goffman wrote an important book in the 1950's called *Asylums*. This sociologic study of total institutions found they have common characteristics. Total institutions include hospitals, nursing homes, mental health facilities and prisons.

Goffman offered this definition: A total institution may be defined as a place of residence and work where a large number of like-situated individuals, cut off from the wider society for an appreciable period of time, together lead an enclosed, formally administered round of life." His study was done at a federal mental health institute in Washington, D.C. He concluded that total institutions had by definition certain attributes such as regimentation and depersonalization. He reported the "staff saw inmates as bitter, secretive, untrustworthy" and that inmates saw staff "as condescending, highhanded and mean."

Goffman suggested the following to combat institutionalism: (1) encourage visitors and family contact; (2) encourage personal belongings, mementos and clothes; (3) encourage home visits and contact in the community, and (4) address people by their correct name, not "sweetie," "honey," etc.

RALPH NADER COMPLEX

There is a belief among certain groups that when a problem is identified a law should be passed. Many issues in society do not lend themselves to correction by legislation. There is no law on the books to make people care about other people, to make people treat other people with kindness, or to cause people to give the proper degree of respect to our elderly. The regulatory process is powerless to make these things happen.

The Department of Health is funded to make up to two visits to a nursing home a year on a regularly scheduled basis. This leaves about 361 days when surveyors are not present and have no knowledge of what really takes place in the facility. The enforcement of minimum standards by the state is under the same burden of proof as any police department. There must be irrefutable evidence to make any charge against a nursing home stand up. The courts have always held that a nursing home has the right to a license, or Title XIX contract, unless proven otherwise. Correction by the

This information on public health matters is furnished and sponsored by the Iowa State Department of Health.

STATE DEPARTMENT/PUBLIC HEALTH

(Continued from page 391)

nursing home of any identified problem has been regarded by the courts as the same as never having happened.

Fear of retaliation among residents of nursing homes, staff members and family members is great. Residents fear they will no longer be welcome and that the staff will be angry with them for having submitted a complaint to the state. This overwhelming fear makes many hesitate to make known a concern lest they be discharged, treated badly, or not "liked" anymore.

COMMUNITY STANDARDS MOST POWERFUL

Where communities have high standards of care for the elderly, the best care is frequently given. Competition among rival providers stimulates activity for the "best state inspection."

Increased physician involvement has shown over and over that where doctors make regular visits to their nursing home patients there is a

better quality of care. The watchful eye of a physician can detect potential difficulties and promote improved conditions.

Increased communication with the owners/operators of nursing homes also can result in improved conditions. Very few operators do not want to provide the best of care to the people in their homes. They usually will appreciate any indication of a less than satisfactory service that is brought to their attention. Only after having been unsuccessful in this way should a person contact the State Department of Health. Informal resolution of problems can be accomplished more speedily and with less hard feelings.

Any citizen with a complaint against a provider of long term health care may contact the Iowa State Department of Health, Health Facilities Division, Lucas State Office Building, Des Moines, Iowa 50319, or call 515/281-4130. Complaints may be submitted anonymously.

The preceding excerpts are from remarks by Dana Petrowsky, director, Licensing and Certification, Iowa State Department of Health, made to the 1981 Conference on Area Agencies and Long Term Care.

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July 1981 Morbidity Report

Disease	July 1981 Total	1981 to Date	1980 to Date	Most July Cases Reported From These Counties
Amebiasis	0	5	7	
Brucellosis	0	0	5	
Chickenpox	70	6978	7427	Clinton
Cytomegalovirus	3	13	15	Johnson, Lee, Polk
Eaton's Agent infection	2	15	9	Dubuque, Polk
Encephalitis, virol	4	11	8	Corroll, Dollos Polk
Erythemo infectiosum	4	1149	398	Clinton
Gastroenteritis (GIV)	69	12208	13362	Johnson, Scott, Black Hawk
Giardiasis	5	24	14	Block Hawk, Colhoun Monono
Hepatitis, A	19	162	93	Clinton, Polk, Linn
Hepatitis, B	6	51	48	Polk, Johnson, Lee
type unspecified	7	37	45	Polk
Herpes Simplex	36	134	59	Johnson, Polk, Linn
Herpes Zoster	0	4	1	
Histoplasmosis	1	7	14	Story
Infectious mononucleosis	0	188	206	
Influenza, lab confirmed	0	191	109	
Influenza-like illness (URI)	323	48551	48833	Johnson, Clinton, Black Hawk
Meningitis oseptic	9	34	15	Polk, Linn, Boone
bacterial	9	83	79	Polk, Clinton
meningococcol	0	18	8	
Mumps	1	41	37	Polk
Pertussis	0	2	0	
Robies in onimals	86	566	267	Dubuque, Story, Keokuk
Rheumatic fever	1	7	0	Scott
Rubello (German meosles)	0	4	7	
Rubeolo (measles)	0	1	20	
Solmonello	36	152	72	Scott, Johnson, Polk
Shigellosis	3	20	32	Block Hawk, Johnson, Lyon
Tuberculosis total ill	10	58	55	Mills, Polk, Scott
bact. pos.	7	38	41	Scottered
Venereol diseases: Gonorrheo	564	2969	2755	Polk, Scott, Block Hawk
Syphilis	1	14	9	Linn

Laboratory Virus Diagnosis Without Specified Clinicol Syndrome: Adenovirus — 1, Black Hawk, 1, Linn; Guilloin Borre Syndrome — 1, Polk; Legion-noire's — 1, Cerro Gordo, 1, Dubuque; Rocky Mt. Spotted Fever — 1, Crawford, 1, Iow, 1, Polk; Coccidioidomycosis — 1, Muscotine; Leptospi-rosis — 1, Ringgold; Coxsockie — 1, Dollos, 1, Scott; Compylobacter — 1, Black Hawk, 1, Butler, 6, Dubuque, 3, Johnson, 1, Morsholl, 6, Polk, 1, Tomo; Toxic Shock Synd. — 1, Humboldt, 1, Johnson.

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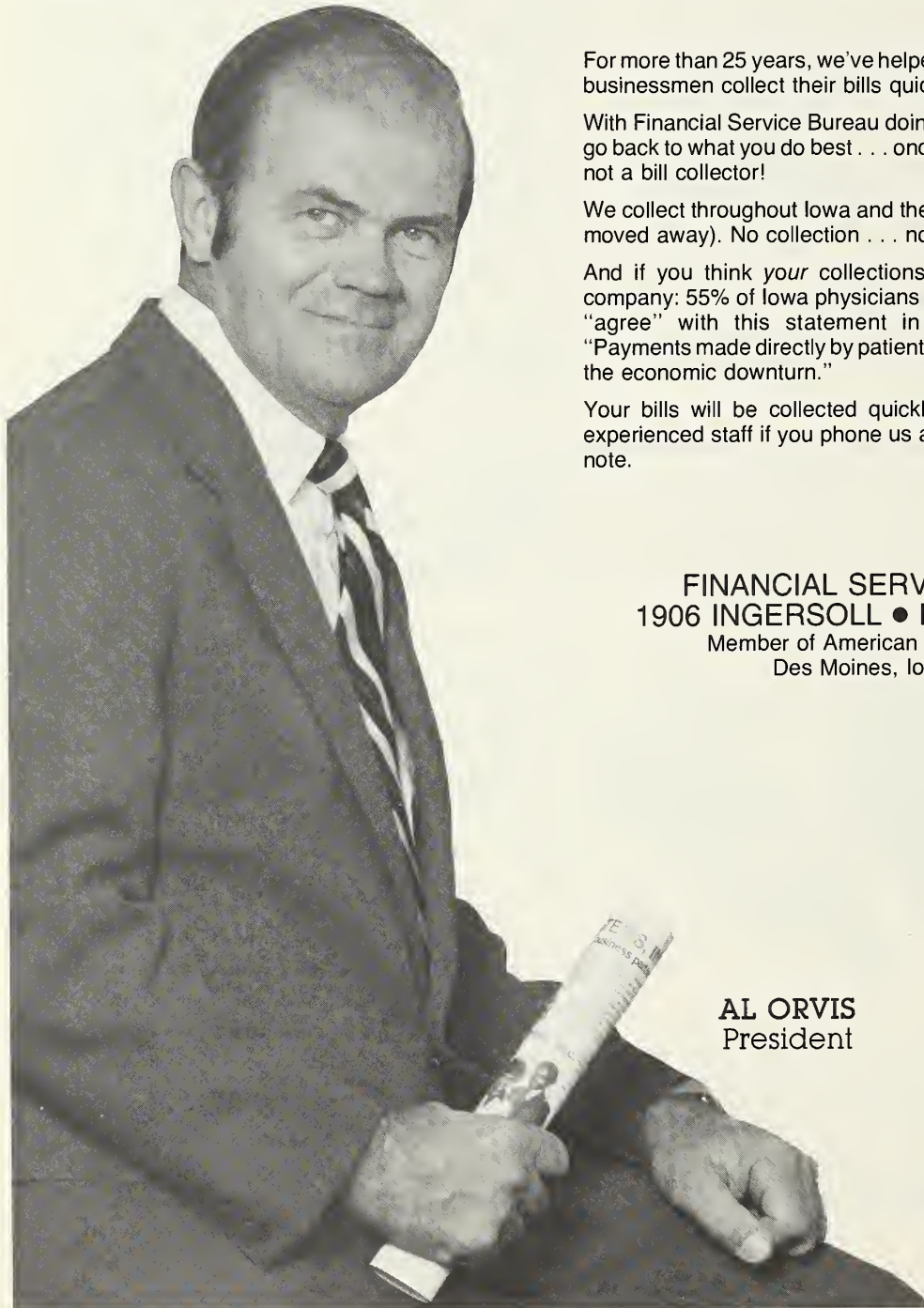
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ABOUT IOWA PHYSICIANS

Dr. R. E. Patterson, Webster City, recently was honored by that community for his 50 years of providing medical service. A U. of I. College of Medicine graduate, Dr. Patterson began his medical practice in Webster City in 1931 following 3 years of postgraduate work at Broadlawns Hospital in Des Moines. He is a past president of the Hamilton County Medical Society; member of the Iowa Chapter, American Academy of Family Physicians and member of the American Society of Abdominal Surgeons.

Des Moines physicians, **Dr. Leo J. Plummer** and **Dr. Thomas A. Brown** have combined and relocated their ophthalmology practices in West Des Moines. Their newly formed joint practice will be known as The Physicians' Eye Clinic. . . . **Dr. Lewis E. January**, professor, Department of Internal Medicine, U. of I. College of Medicine, was honored recently for 44 years of faculty service. A photographic portrait was presented to him by his colleagues to be permanently displayed in the Lewis E. January Learning Resources Unit of the College of Medicine's new Cardiovascular Center; this is to be dedicated later this year. . . . **Dr. Walter L. Mendenhall, III**, has joined **Dr. Mary Gannon** in the practice of urology in Spencer. Dr. Mendenhall received the M.D. degree at the U. of I. College of Medicine and completed his urology residency at Indiana University Medical Center in Indianapolis. . . . **Dr. Morris Benson** recently began family practice in Nashua. Dr. Benson received his medical education at the University of Calgary, Alberta, Canada and served his family practice residency at the State University of New York and the University of Alberta Hospital in Edmonton, Alberta, Canada. Prior to locating in Nashua, he practiced family medicine in Lemmon, South Dakota. . . . **Dr. Daniel B.**

Eggers has been named president of the Waverly Hospital medical staff; **Dr. Michael T. Berstler** is vice president and **Dr. David B. MacMillan** is secretary-treasurer. All are Waverly physicians.

Recognition certificates recently were awarded by the Family Practice Residency Training Program at Broadlawns Medical Center to the following Iowa physicians — **Drs. John C. Bardole; James Blessman; George G. Caudill; William D. deGravelles; Wendell K. Downing; Thomas A. Ericson; Randall R. Maharry; Stewart O. Olson** and **R. Douglas Paul**, all of Des Moines; **Dr. John L. Banks**, Cedar Rapids; **Dr. Paul Groben**, Charles City; **Dr. Dean A. Nierling**, Cresco; **Dr. Stephen Paulk**, Waterloo, and **Dr. Subhas Sahai**, Webster City. . . . **Dr. Paul Pettit** has joined **Drs. Robert Hedican** and **Stephen Bloom**, Waterloo physicians, to practice gynecology and obstetrics. Dr. Pettit received the M.D. degree at Creighton University School of Medicine and completed his obstetrics and gynecology residency at the

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Mayo Clinic in Rochester, Minnesota. . . . **Dr. Terry D. Van Oort** recently began family practice in Ankeny. Dr. Van Oort received the M.D. degree at U. of I. College of Medicine and completed his family practice residency at Broadlawns Medical Center in Des Moines.

U. of I. College of Medicine and began his medical practice in Humboldt in 1940. He is a past president of the Iowa Academy of Family Physicians and currently an alternate delegate to the American Academy of Family Physicians.

DEATHS

Dr. Floyd O. Woodard, 89, former Des Moines physician, died July 18 at a Santa Barbara, California, hospital. Dr. Woodard received the M.D. degree at U. of I. College of Medicine. He practiced medicine in Des Moines for 31 years, prior to retiring in California.

Dr. Alwyn R. TouVelle, 60, Bettendorf, died July 27 at St. Luke's Hospital in Davenport. Dr. TouVelle received the M.D. degree at the University of Illinois School of Medicine, and began his medical practice in Bettendorf in 1950. He was physician to the athletic department of Bettendorf High School for 30 years and the new Bettendorf High School football stadium, to be dedicated in September, has been named TouVelle Stadium. He was a recipient of the

(Please turn to page 398)



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(Continued from page 397)

Iowa High School Athletic Association's team doctor award and was to be recognized this fall at a convention of the American Academy of Family Physicians for his contribution to family medicine.

Dr. William C. Keettel, 70, professor emeritus of the Department of Obstetrics and Gynecology at U. of I. College of Medicine, died July 28 at his home. Dr. Keettel received the M.D. degree at the University of Nebraska; interned at the Indiana University Medical Center and completed his residency in obstetrics and gynecology at the U. of I. Following military service in World War II, Dr. Keettel joined the faculty of the U. of I. College of Medicine. He was appointed head of the Department of Obstetrics and Gynecology in 1959, a position he held until 1977. He became professor emeritus in 1980. Dr. Keettel was a recipient of the Distinguished Service Award of the American College of Obstetricians and Gynecologists; past president of the AAOB, the Central Association of Obstetricians and Gynecologists and the Iowa Obstetric and Gynecologic Society.

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OCTOBER 12-13, 1981 — SOUTH DAKOTA PERINATAL ASSOCIATION SIXTH ANNUAL CONFERENCE, "Current Issues in Perinatal Care," Holiday Inn of the Northern Black Hills, Spearfish, South Dakota. 9.6 Continuing Education Credits applied for. Guest speakers include: Preston Dilts, M.D.; John Grossman, M.D.; George McCracken, M.D.; Lu-Ann Papile, M.D. Contact Maro Varcoe, R.N., Program Director, S.D.P.A., 1100 S. Euclid Avenue, Sioux Falls, South Dakota 57105. 605/339-6578.

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This sage declaration is attributed to Philop-
pus Aureolus Paracelsus. He was a Swiss
physician circa 1493. As they say, Paracelsus
may have been slightly ahead of his time. His
advanced theories are said to have foreshad-
owed modern medical science.

In the opening quotation we assume our ear-
ly physician friend equated understanding
with learning. Few would argue the parallel.

Learning is a hallmark of the medical profes-
sion. Assimilation of new information is an
infinite proposition for the physician. It's a life-
long endeavor proceeding from student days.

The preceding is said as the Fall season ar-
rives. Our calendar begins with January. But
people's minds seem to key on September as
the time when much of society's formal pro-
gramming starts in earnest. This thinking is
generally applicable to continuing medical
education (CME).

Around Iowa the CME momentum picks up
in the Fall. The CME accredited agencies un-
veil numerous possibilities for physicians and
other health care providers. What, for exam-
ple, is on tap in Iowa this Fall?

Well, the 1981/82 medical education pro-
gram at St. Joseph Mercy Hospital in Mason
City has a September 16 presentation called
"Radiology of Facial Fractures" given by
Charles G. Jacoby, M.D., Iowa City. On Octo-
ber 6, also in Mason City, a program entitled
"Ear Diseases, Ear Pathology and Vertigo" will
be presented by Richard Babin, M.D., Iowa
City. Both are University of Iowa medical
faculty.

Elsewhere in the state, the Cedar Rapids
Medical Education program has a gastroenter-
ology review for area physicians beginning
October 5. Earlier, on September 25, Dennis
O'Leary, M.D., famed for reporting the condi-
tion of wounded President Reagan, will be in

Cedar Rapids to give his interesting case study
on how to translate medicine to the media and
the public.

Illustrative of CME activity in central Iowa is
the Fall program at the Iowa Methodist Medi-
cal Center. Included is a September 10 session
on juvenile hypertension by Jennifer Loggie,
M.D., pediatrics professor at the University of
Cincinnati, U. of I. faculty will be at IMMC
October 15 to discuss food allergies in infants.
Then November 19 Martin Myers, M.D., also
from the U. of I., will present information on
herpes simplex virus.

In far-eastern Iowa programming is planned
by the Mississippi Valley Regional Blood Cen-
ter. A September 3 conference on the treat-
ment of hemorrhagic shock will feature Wil-
liam Chamberlin, M.D., assistant director of
the intensive care unit at Michael Reese Hos-
pital in Chicago. On November 18 a session on
therapeutic hemapheresis will be given by
Jacob Musbacher, M.D., Rochester, N.Y.,
director of blood services, American Red
Cross.

ON THE OTHER SIDE of the state CME pro-
gramming at Jennie Edmundson Memo-
rial Hospital in Council Bluffs will include an
October 13 session on hyperlipidemia by Car-
los DuJovne, M.D., Department of Pharmacol-
ogy, University of Kansas Medical Center.

These events tell a bit about how Iowa physi-
cians stay informed. All of the organizations/
institutions mentioned are specifically CME
accredited through the Iowa Medical Society.
Other accredited CME bodies in Iowa include
the Iowa Heart Association; Mercy Hospital
Medical Center, Des Moines; Burlington
Medical Center; Mental Health Institute, Cher-
okee, and the Black Hawk Area Medical
Education Foundation, Waterloo. Of course,
the University of Iowa is fully accredited as an
interstate CME provider.

The IMS has a part in helping assure the
quality of this statewide CME activity. But it's
the effort of local physicians and their associ-
ates that really makes it all work.

Amen, Paracelsus! Welcome Fall!

September 1981

Journal of the Iowa Medical Society



"Your suit is ready, doctor," said the tailor

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Constructive Compassion Versus Conspiracy of Silence

HORMOZ RASSEKH, M.D.
COUNCIL BLUFFS, IOWA

REACHING OUT to help a colleague is the essence of the Iowa Medical Society Assistance Program for Troubled Physicians. The APTP was inaugurated by the Society almost one and a half years ago.

As with various types of endeavor, the delivery of medical care offers a more vulnerable environment when it comes to emotional stress, physical ailments or aging. Long hours of treating patients often leaves the physician with little personal time for important diversion in the family or recreational sense. As a result, stress occurs. To cope with pressures of schedule, many physicians turn to alcohol, drugs or other outlets.

In other instances personally overlooked problems associated with age and/or disability may hinder the ability of the physician to continue to practice with the same precise skill his/her specialty requires. The ability to direct patient care may diminish quite imperceptibly.

Even though the early signs of a problem are usually first recognized by those closest to the physician, e.g., family, colleagues, friends, these individuals oftentimes deny their existence. They are reluctant to acknowledge any change in the behavior of an associate. They are naturally reluctant to admit the fellow physician has a practice that is not up to par. A conspiracy of silence begins.

In addition to serving presently as president-elect of the Iowa Medical Society, Dr. Rassekh is chairman of the IMS Committee on Assistance Program for Troubled Physicians. He is in the private practice of psychiatry in Council Bluffs, Iowa.

Thirteen Iowa practitioners have known the constructive compassion of the Iowa Medical Society Assistance Program for Troubled Physicians in its 16-month existence. The "no red-tape" program is voluntary and exists specifically to help remedy troubles before they become impairments.

The Iowa Medical Society has an alternative available. It is a program of constructive compassion. It provides help before any problem seriously threatens the well-being of the physician or, equally important, his/her patients.

The APTP is a voluntary and a non-coercive program through which troubled physicians are encouraged to seek treatment and rehabilitation. The total effort of the Society is designed to preserve the professional competency and reputation of the physician.

It is required by Iowa law that physicians report to the State Board of Medical Examiners any first-hand knowledge of "acts or omissions" which impair the ability of a physician to practice "with reasonable skill and safety." Such situations must be explored by the Board of Medical Examiners to see if there are grounds for revocation or suspension of a license. Included here obviously are habitual intoxication or addiction to the use of drugs.

Clearly, the primary objective of the Society's APTP is to eliminate a problem before impairment occurs. The IMS program was established in the belief that almost any problem can be resolved successfully if it is recognized and treated early enough. Information on the existence of this service has been made known to members of the Iowa Medical Society and its Auxiliary, as well as to representatives of the

Iowa Hospital Association and Iowa Nurses' Association.

Thirteen physicians have been contacted personally over the 16 months in which the APTP has been active. These individuals have received help from colleagues directly involved in the program.

APTP operational procedures are simple. There is neither "red-tape" nor detailed record-keeping. A committee of 6 physicians oversees and directs the program. These individuals are knowledgeable about abuses and conditions which could lead to physician impairment. The committee is composed of 2 psychiatrists, a surgeon and 3 family physicians, one of whom serves as director of an alcoholism rehabilitation unit.

The APTP committee works with a cadre of "physician advocates" which has a major role in assuring that a troubled physician seeks and receives appropriate treatment/rehabilitation.

Requests for assistance can be directed to the APTP at IMS headquarters, either by telephone or letter. A single staff member has been assigned to handle all initial inquiries. After contact is made with the Society the following steps are taken:

1. *The chairman of the APTP committee is notified immediately. He makes necessary arrangements for appropriate follow-up contact by a physician advocate.*

2. *The advocate contacts the writer/caller to verify the existence of a problem.*

3. *After it is determined there is sufficient reason for action, the advocate confirms arrangements for a personal visit with the troubled physician and, if necessary, other involved individuals, e.g., family members, colleagues.*

4. *The advocate encourages the physician to seek help voluntarily; assists him/her in entering treatment; maintains contact and provides encouragement and support during a course of treatment.*

5. *After treatment and/or rehabilitation have been completed successfully, the APTP intervention is concluded.*

If such is requested, the name of the individual who is seeking help for a troubled physician will not be disclosed. In addition, all information concerning a physician receiving assistance is held confidential. It will not be revealed except as necessary to the effective operation of the program. However, under the

law, if impairment is identified during the advocacy process, appropriate referral must be made by the APTP committee to the Board of Medical Examiners. The BME is then responsible for conducting its own inquiry.

The APTP not only provides direct help to troubled physicians, it is also involved in educational activities. Recognizing physicians are vulnerable to the same afflictions that confront their patients, the APTP encourages open discussion of problems which can lead to impairment.

A new film entitled, "Our Brother's Keeper," is available to show to medical and other interested groups. Any such program will include supplemental discussion by a member of the APTP committee. The film portrays dramatically the problems of an alcoholic physi-

**WHEN HELP IS NEEDED
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cian, and how he, his family and his colleagues deal with them.

The committee has also met with representatives of the University of Iowa College of Medicine to discuss ways to increase the awareness of physicians-in-training about the potential problems which stem from stress and the abuse of alcohol and drugs. Such problems are an "occupational hazard" for physicians, and physicians-in-training must be sensitive to them if appropriate preventive measures are to be taken. Programs are being developed to accomplish this goal.

The Iowa Medical Society will continue to give high priority to its Assistance Program for Troubled Physicians. Hopefully, through this effort, Iowa physicians will be helped in coping with and guarding against problems which could adversely affect their ability to provide high quality medical care to their patients.

My Brother's Keeper

PHYSICIAN ADVOCATE
ANYWHERE, IOWA

WHO CARES about the physician when he is ill?

Most physicians supply medical needs to a colleague — or his family — unhesitatingly. We honor a long standing professional tradition when we do so.

But do we? As fully as maybe we should?

The author is in the private practice of family medicine. He has chosen to contribute time as necessary to serve as an advocate in the Iowa Medical Society Assistance Program for the Troubled Physician.

Do we enter the personal and sensitive sanctum of a troubled physician with a word of firm concern? I have chosen to trespass this zone, says this IMS physician advocate. A forthright confrontation is an absolute in scaling the wall of denial.

Observers say we have the equivalent of one medical school class dying each year from alcohol/drug abuse. We supposedly lose another class to suicide.

So do we supply compassionate care as fully as we should? Do we enter the personal and sensitive sanctum of our troubled colleague to bring a word of firm concern? Do we lack the

Thanks for the Help

TROUBLED PHYSICIAN
ANYWHERE, IOWA

IF YOU are looking for a drunkalogue, stop here. I will be using the terms alcoholic and alcoholism. They will refer to any person, or condition a person incurs, relative to a mood altering chemical. I include *uppers, downers, smoother-outers, tranquilizers, or alcohol.*

Various minor mood altering chemicals were involved in my case. But my drug of choice was alcohol. *Thanks for my life!* I am sure I would have been dead in another year or two had I continued on my course. Most very likely physically dead, but assuredly mentally and/or psychologically dead.

The author has been a private practitioner in Iowa for many years. His confrontation with an IMS APTP physician advocate was an important part of the turnaround process.

Initially, I thought the IMS physician advocate was the most supercilious, sanctimonious jackass I had ever met. But he was still one of the first to call a spade a spade. These are among the personal comments of this troubled physician who says, if you see yourself in these remarks, seek help and seek it now.

Thanks for my health! I was obese (230 lbs.), severely hypertensive (220/110), tachycardiac (80 per minute at rest), hepato-cardiac enzymes in disarray, and early EKG changes. Today my weight is 173, blood pressure 130/80 at rest. My heart rate is 56 per minute at rest. My enzymes and EKG are presenting normal.

These are the objective changes in my health. The changes in my mental health are much more elusive. I do not feel qualified to describe them. This is best left to those who know me.

courage to urge that help be considered?

I have chosen to trespass this zone. As others have. With fear and trepidation at times. But also with ultimate gratification at other times.

The pain and suffering encountered by a troubled physician and his/her family is not really amenable to statistical analysis. They must be experienced and/or observed first hand. We can recite figures from studies, but these pale alongside the impact of witnessing personal and tragic self-destruction.

As a physician, I have chosen to render advocacy to the troubled colleague. When his/her actions say that the future may be in jeopardy from the use of mood altering drugs, I have agreed to be an intervenor. To remain silent and allow the illness to progress may be to watch my colleague die. The illness of addiction is potentially fatal if not arrested. Fortunately, it is also treatable. To treat the illness, the parties concerned must identify it and accept it. This discussion is not meant to decide whether alcoholism/drug abuse is an illness or a bad habit. That debate can be held another time.

The fact is people who suffer from alcoholism/drug abuse often die unless the process is arrested. See if you can accept this thesis: If the use of alcohol, or other mood altering drug, manifests itself in physical, mental or social deterioration, then we have a problem. Usually, as we know, the problem emerges subtly and gradually. The physician's family suffers first. Other activity within the societal framework begins to suffer. The impact on professional life usually comes later, and may be less readily identified. Frequently, here, it is ancillary medical personnel who observe the altered behavior before it comes to the attention of the physician's colleagues.

As an advocate for the troubled physician, I can be responsible to him, but not for him. He requires firm confrontation about his problem. To scale the wall of denial, a direct presentation of the facts is best accomplished with at least two physicians. Preferably, one of the confronting physicians has dealt with the problem personally. Additional support from a practice associate is normally well advised.

Often the troubled physician's spouse and

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Thanks to my wife! She is the most extraordinary woman I have ever known, or hope to know. Any lesser woman would have dumped me years ago. Fortunately for me and our children, she was one of the "old sod," who took her marriage vows seriously, except possibly the "poor bit." We couldn't have been much poorer at the time.

Thanks for my family! I mean this in the broad sense. Not only our children, but all members of the human family, my associates, my friends, and my counselors. In some way they all contributed to my recovery.

My major stumbling block to seeking rehabilitation was myself. I was a recalcitrant, obstreperous, cantankerous and downright truculent person. No one would approach me and tell me I was an alcoholic. Not until in desperation did I seek a way out of my jungle. Only then did any one have the guts to say I was impaired, and even then it was not an associate.

Still I cannot say I did it on my own. My own way worked — for a while, about a year and a half. I lost weight, had a decrease in blood

pressure, and was on an exercise program. My practice improved as did relations with associates. My family life also improved. I prayed; God, how I prayed. I thought I did it. I thought I had control and had won the battle of the bottle. But I got complacent, and at that point I nearly lost the whole ball game. My alcoholic temperament was still with me. For the life of me I could not shake it.

In somewhat diverse ways many people helped me into treatment. My wife continued her unfaltering confidence in me. I knew I was headed into rough water and was unsure which way to turn the rudder. My children also helped, although I expect a good amount of their mother's attitude rubbed off on them. My associates helped in the sense that they were making (I thought) my life so miserable, that somewhere, somehow, I had to find a solution.

Then came my first encounter with an Iowa Medical Society advocate. I thought him initially to be the most supercilious, sanctimonious

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MY BROTHER'S KEEPER

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family are non-committal at first. At times they will resent the assertion that a problem even exists. It is as if alcoholism is an accusation rather than a diagnosis.

After the initial denial is overcome by a persistent recitation of the facts, and the predictable angry response abates, the options can be discussed. The options are *treatment*, or *treatment*, or lastly *treatment*. This treatment is best obtained at an in-patient facility which has experience in serving professionals. The family must be involved in the recovery process as they have been in the illness. The same can be said of the physician's colleagues; they can benefit from a further understanding of the illness and the recovery process.

If the troubled physician is unable to accept the recommendation of the advocate, and/or his colleagues, close observation and continued involvement are recommended. The protection of the public is a crucial factor. When the safety of patients is threatened, it is necessary then, and only then, to involve the Board of Medical Examiners. A troubled physician may declare he will not seek treatment, "for love, nor money." That is exactly why he

THANKS FOR THE HELP

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jackass I had ever met. *He was still one of the first to call a spade a spade.* Even after that six weeks and no further action was taken. I was forced to seek my own recourse.

Thanks for my profession! There is nowhere else I can think of that a person has the opportunity to do more good for his fellow humans than in medicine. A physician is sought out and respected, but must in return handle that trust with reverence.

There are as many types of alcoholics as there are types of people. I simply illustrate one. I have characteristically solved my problems by meeting them head on. If I could not go over, under, or around them, I would back up and run full to smash them. This method always worked for me until the problem of alcohol.

will go to treatment. The loss of those who love him and the loss of his profession are the bottom line.

We know alcohol has been a cultural tranquilizer for over 6,000 years. Its production, sale and use receive critical attention from legislators, law enforcement officials, the courts and other government entities. We have cultural definitions to cover its acceptable use — and its unacceptable use. Regardless of our centuries of experience, alcohol remains a curse for many. The problems connected with its use are well known to the medical profession. Yet, despite our education, training and practice experience, physicians are far from immune to its seduction and destruction. In fact, studies suggest physicians are at twice the risk of becoming chemically dependent as the general population. Fortunately, our potential for recovery is also much greater.

As with many things, early attention is valuable. When attention is required, regardless of the stage of progression, it is important I (or you) not allow my (or your) colleague to use excuses, to make promises he will "get straightened out." I am certain there are exceptions, but in my experience the opportunity for successful recovery is greatly enhanced by completion of a treatment experience at a quality treatment center.

I knew a great amount about alcohol. I could lecture for hours about alcohol, its chemistry, its pharmacology, its physiology and pathology. But I knew nothing about alcoholism. It is cunning, baffling and insidious. It is a thief that can rob you of everything you hold dear. Everything becomes vulnerable, your health, your family, your practice, your friends, your self respect, and eventually your life. An alcoholic is an enigma, a paradox who keeps returning to the arena to fight alcohol knowing full well he could do nothing but lose.

Thank God, at least to the best of my knowledge, I never jeopardized a patient in any way. Knowing what I know now however, it would have only been a matter of time.

If any of you out there see yourself in this article, please, I beg of you, seek help and seek it now. In summary, *I thank God*, and whomever, or whatever, for my life, my health, my wife and my family, and my profession.

I thank you for listening.

APTP — It Would Have Helped

STAN HAUGLAND, M.D.
DES MOINES, IOWA

TO SEE THE Iowa Medical Society Assistance Program for Troubled Physicians become reality has special meaning for me. That's because of my own personal experience with addictive illness. When I reflect on the 10-plus years I was in the throes of active alcoholism I cannot help but wonder if things might have been different or easier had this program been available. When I say easier, I mean producing less anguish for my family, less concern by my colleagues and better care for my patients.

Much is now known about the early signs and symptoms, medical complications and the inevitable socio-economic dysfunction of the addictive illness called alcoholism. For example, Donald Goodwin, M.D., University of Kansas Medical School, has concluded there is a strong hereditary tendency to develop alcoholism. This is exemplified among sons of alcoholics who have a four times greater frequency for the illness even if adopted out in the first few weeks of life and raised by non-alcoholic parents. In other words, the notion it is due mainly to environment is very naive.

Further, increased tolerance for alcohol, an important symptom in establishing this di-

Speaking from the heart about his own trials with alcohol, this physician author thinks had the IMS effort to help troubled doctors existed in an earlier time, it might have spared him and his family much grief. He urges Iowa physicians to be watchful of their colleagues and to be part of early compassionate intervention where it is needed.

agnosis, is most certainly under genetic influence. Additionally, the magnitude of the euphoria and dysphoria of the alcoholic is apparently greater than the social drinker experiences and has been thought to be genetically determined (which may be an important clue in the addictive process). In truth, the nature of addictive behavior remains a mystery today, but widely expanded basic research is providing additional insight which may give some definitive answers within a decade.

Meanwhile, the critical fact is chemical dependency in the form of alcoholism is widespread throughout society; one in 13 who drink develop the illness. Physicians appear to be at greater risk, so much so that most indicate one in 10 may be afflicted. To add to the burden of early diagnosis, one must recognize that delusion and denial are integral parts of the illness and, as a result, one rarely spontaneously seeks help. Strong encouragement or pressure is often required by family, friends, colleagues and sometimes by duly constituted authority before the chemically dependent person will seek help. This pressure usually peaks with some unfortunate event that is associated with the use of alcohol or other mood altering drug. It is of such an extent that

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Dr. Haugland is the medical director of the Powell III unit at Iowa Methodist Medical Center in Des Moines. He practiced family medicine in Iowa for many years prior to assuming his present position. He serves as a member of the Iowa Medical Society Committee on Assistance Program for Troubled Physicians and Committee on Alcoholism and Drug Abuse.



**They aren't thinking
about medical necessity.**
(Because their physician did.)

In addition to the significant cost savings associated with ambulatory surgery programs, same-day surgery reduces apprehension for patients facing hospitalization.

Blue Cross and Blue Shield of Iowa support outpatient programs when medically appropriate as a means to reduce the cost of health care in our state, and at the same time provide the benefits of recovery and recuperation in the home with less time away from family and work.

The Iowa Foundation for Medical Care (IFMC), with input from the Iowa Medical Society and Blue Cross and Blue Shield of Iowa, have developed a list of surgical procedures that can be safely performed in an outpatient setting.

We encourage physicians to familiarize themselves and their patients with the IFMC's list and seek outpatient arrangements whenever medically appropriate.



APTP — IT WOULD HAVE HELPED

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those close by recognize something must be done to avert disaster or further embarrassment.

From my work experience in this field the past six and a half years I now understand no one truly *volunteers* for treatment of alcoholism/chemical dependency. In actuality it is a "forced" decision to seek help, because the old games do not work anymore, defense mechanisms breakdown or significant health problems arise. Unfortunately, it often takes years of dysfunctional living before someone around the patient is willing to intervene and even then does so most reluctantly. Thus, the average admission age to the inpatient program I direct is 39 years. The admittee has usually demonstrated dysfunctional living from drinking or use of other drugs for 10 to 15 years. Even though the vast majority of these patients are "voluntary" (as opposed to the less than 10% who are court committed), all are, in a sense, forced into treatment. Pressures from family, friends, co-workers, physicians or legal authority "forced" them to look at their behavior and do something about it.

"Intervention" is relatively new as a planned technique for the patient. It was nonexistent 25 years ago when I needed help. I recall vividly the time when two colleagues talked to me because of concern (of patients and medical staff) about my drinking behavior. Most certainly it was well meaning, but it came across more as a serious warning rather than "you may have a sickness and require help." It made me strive harder to keep my abuse hidden. And therefore it did not provide any significant help for my family or my patients. The fear, shame and guilt associated with this confrontation were difficult to bear, but they were not unbearable enough to force me to seek help at the time.

It was not until several years later — when I could no longer work — that I "volunteered" for treatment. I reasoned, since all was lost anyway, I might as well go to a treatment center. All was not lost, as the years have proved, but at the time it seemed so. I see now from a treatment standpoint this is a good starting

point for the patient. If the patient still has a game to play or another angle to work he or she will resist doing anything about it. What intervention does is raise the psychological bottom so one appears not to have any viable alternative. Thus, at age 39, I entered a treatment center in the twin-city area, leaving behind a confused and bewildered family and a community without a physician. That first day in treatment was the worst day of my life. However, it marked the beginning of a new life — one in which I envy no man.

If the *IMS Assistance Program for Troubled Physicians* had existed could the course of events have been changed? Would my family have suffered less or my patients been less inconvenienced? It is likely things could have been different and a thoughtful, well planned intervention could have occurred much earlier. We have now witnessed several instances of intervention in the APTP, of colleague helping colleague with a caring attitude, conveying to the victim and the patient that there is hope for recovery.

Perhaps physicians are more vulnerable due to the easy availability of alcohol and other mood altering drugs. Unfortunately, most physicians can hide their use of pharmaceuticals — and thus obscure their problem longer. And we know the longer the illness is present the poorer the prognosis.

I believe it is incumbent on us to help each other in much the same way we help our patients. We need to be alert to our own use of alcohol and other chemicals. We need to be informed about the signs and symptoms of early alcoholism and chemical dependency. Undoubtedly our own attitudes and our willingness to ask for help through the APTP are the keys to progress — or the lack of it.

In the years since my treatment, there has been personal satisfaction from seeing others recover from this illness. The fruits of intervention and treatment have been great and far outweigh the disappointment of the failures. Whether one succeeds or fails is not the main point. Rather it is putting forth one's best effort on behalf of our fellow human beings; that's where the inner satisfaction is. I truly believe the old philosopher who said, "One of the beautiful compensations of this life is that no one can sincerely help another without helping oneself."

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QUESTIONS - ANSWERS

ALEXANDER ERVANIAN, M.D.
Des Moines, Iowa

VIEWS OF BME CHAIRMAN

Dr. Ervanian is reasonably new to the chairmanship of the Iowa Board of Medical Examiners. He is in the private practice of pathology in Des Moines. His comments here provide additional insight to the impaired physicians.

As chairman of the Board of Medical Examiners, you know first hand about problems encountered by Iowa physicians. How do you assess the magnitude of the problem?

In calendar 1980, 293 complaints against physicians were registered with the Board of Medical Examiners. This represents approximately 9% of the registered physicians. However, several of these complaints concerned problems in other states and did not involve active licensees of the State of Iowa. If we realize several multiple complaints existed against a few physicians it appears that approximately 8% of the Iowa licensees had complaints filed against them in calendar 1980. The types of cases reported to the Board of Medical Examiners are as follows: 36 cases related to alcohol use, drug abuse, and excessive prescription of controlled drugs; 33 cases involved ethics and conduct problems; 112 related to physician competency; 3 cases had to do with mental problems; 82 cases were reported as a result of malpractice suits; 7 were in a miscellaneous category; 6 cases were licensee discipline from other states; 1 case was a violation of

probation; and 13 cases involved practicing without a license. These latter were not cases registered against physicians.

Because of the large number of cases, and the shortage of investigators, we completed only 63 of the approximately 270 cases in calendar 1980. It is important to note approximately half of the cases closed were found to be without merit and no sanctions were imposed. In slightly more than half of the completed cases there was justifiable cause for action and sanctions were imposed against physicians in 36 cases. 22 of the 36 cases involved only letters of warning and no additional formal action. The largest number of complaints handled were in the category of ethics and conduct and competency.

I do not believe Iowa physicians have any more problems than counterparts from other states. This apparent large number of reported cases reflects public awareness, which Iowa law encourages. And it demonstrates the willingness of the Board of Medical Examiners, as required by Iowa law, to pursue diligently complaints against physicians. I know many other states have few cases referred to the medical examiners. Some states with much larger populations have fewer sanctions against physicians than we do. I believe this reflects the inactivity of these boards and a lack of public awareness and interest.

Has the situation (in number of problems and severity of situations) worsened during your service on the BME?

Unquestionably, the number of cases reported to the Board of Medical Examiners has increased significantly during my time on the Board of Medical Examiners. In the calendar year 1977, 39 complaints were registered; in 1978, 75 complaints were registered; in 1979, 187 complaints were received by the Board of Medical Examiners and in 1980, 293 complaints were received. I believe the numbers speak for themselves, but a word of caution is necessary. Since 1978 all malpractice suits instituted against Iowa physicians were automatically reported to the Board of Medical Examiners. This has increased markedly the complaints against physicians, but only a small percentage of these cases will ultimately result in sanctions

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Alcoholism, Dilemma or Disease: A Recurring Problem for The Physician

RICHARD FINN M.D., and
JOHN CLANCY, M.D.
Iowa City, Iowa

SOCIETY KNOWS WHAT IT WANTS TO DO about its alcohol problem but cannot find an effective way of doing it. It wishes to preserve the individual's freedom to drink for pleasure, but at the same time it seeks to curb the deviant behavior of those whose pleasure is drinking to excess. Where does the one stop and the other begin? To mark a boundary between acceptable drinking and excessive drinking of alcohol, and to warn or contain those who trespass into alcoholism, a variety of coercive and persuasive controls are supported by government, religion, and other institutions. Governments regulate the sale and consumption of alcohol and punish those whose drinking behavior becomes troublesome. Religion condemns overindulgence as sinful. Educational programs developed by both discourage the

use of alcohol. The results of these efforts are unimpressive.

In an effort to achieve greater control, society has in recent years started to shift responsibility for the alcohol problem onto another segment of society, the medical profession. The basis for this shift is the assumption that excessive drinking or the deviant behavior associated with it is evidence of illness. No longer regarded as either criminal or sinful, excessive drinking is to be regarded as a sickness to be treated by physicians. Despite a decade and a half of continuous pressure and propaganda from medical organizations and federal and state health agencies, most doctors still do not accept the thesis that alcoholism is a disease and alcoholics are proper patients for them to treat.¹ The purpose of this article is to examine the conceptual and practical problems presented to doctors by society's expectation that doctors will accept alcoholism as a sickness and alcoholics as patients.

Whenever the physician accepts the expectations of society that he will consider the alcoholic a sick person and will treat him accordingly, the doctor by his training cannot help but view the alcoholic and his deviant behavior within the context of the sick role. Such a role is subject to the cultural concepts and conditions which underlie and determine

The authors are associated with the Department of Psychiatry, College of Medicine, University of Iowa. Dr. Clancy is a professor and Dr. Finn is an associate professor.

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THE IOWA MEDICAL FOUNDATION HAS DESIGNATED THIS ARTICLE AS THE HENRY ALBERT
SCIENTIFIC PRESENTATION FOR THE MONTH OF OCTOBER 1981

modern American medical practice. The sick role is a very special one in our society. It is an accommodation protecting the sick person from a loss of society's approval and support, while, at the same time, protecting society from an epidemic of self-serving illness. The sick role confers two rights upon the sick person in exchange for the fulfillment of two duties.² The first right is exemption from normal social responsibilities. The second is recognition by others that a sick person is without blame for his illness or its consequences. In return for having his illness considered a legitimate social condition, the sick person must fulfill two duties: one is to sincerely want to get well, while the second is to seek technically competent help and cooperate with those people providing help. Illness, then, to be legitimate should be temporary if possible.

The physician also has obligations he must meet. He must have a considerable technical competence. He must approach his patients with emotional neutrality and objectivity, yet not be insensitive to their suffering. Under these conditions, he can develop effective working relationships with committed and responsive patients. More important, however, it enables both doctor and patient to meet the expectation each holds for himself and for the other.

IT IS VERY APPARENT that these mutual expectations are not always fulfilled between a physician and his alcoholic patient. Many physicians, therefore, are reluctant to give excessive drinkers the privileges of the sick role when so many of them will not accept or maintain their sick role obligations. It is also probable that physicians are reluctant to establish doctor-patient relationships with deviant drinkers because of their uncertainty about the management responsibilities to which they will obligate themselves. This uncertainty arises from the different ways we look at alcoholism and from the different conceptions we hold in regard to it. According to Mechanic's formulation of the social concept of disease,³ whether the deviant behavior of excessive drinking is called alcoholism — a sickness or drunkenness, a crime or sin — depends upon the frame of reference of the person picked to evaluate the behavior. If the evaluator believes

in his self-interest, then, when drinking reaches deviant proportions, the evaluator will tend to call it criminal or sinful. On the other hand, if the evaluator believes that the drinker cannot control his drinking or that his drinking is at odds with his self-interest, then the evaluator will tend to call it illness. The physician cannot permit himself the liberty of such a conflict in theory because it may lead to indecision or inconsistent action.

The illness frame of reference could provide a physician with a firmer foundation for action and decision making. Under it, moral or social judgments are less likely to be influential factors and even when they are encountered, as, for example, in venereal disease, the necessity for treatment is still accepted. This medical model, or as Mechanic⁴ calls it, the diagnostic approach, is the basis for general medical practice. According to it, a doctor's understanding of the patient's situation and the appropriate treatment follow directly from the diagnosis. He can predict the future to some extent; he can make his decisions with some degree of certainty; and he can comfortably take responsibility for his activity under this model. As we have seen, however, physicians have not yet conceptualized alcoholism as a disease and therefore, it does not fit into the diagnostic and therapeutic scheme.

Medicine is an uncertain business, and uncertainty in respect to a patient can be most disturbing to the physician. One way a physician can usually increase certainty is to increase his control over a situation. Control is an important issue with doctors. Doctors like to feel that they have control over their diagnostic and therapeutic efforts,⁵ and the way they typically maximize their certainty is by maximizing their authority in the doctor-patient relationship. Szasz and Hollender⁶ have emphasized the importance of control in the doctor-patient relationship. They have described three types of such relationships based on the amount of control over decision-making held by doctor or patient. The first of these is the activity-passivity type. Here the doctor is active and the patient is passive, taking no part in making decisions. In fact, the patient may not even take part in establishing the relationship. This type is reserved for those illnesses in which the patient is stuporous, delirious,

(Please turn to next page)

or severely psychotic. In the of field alcoholism they are represented by such conditions as acute intoxication, alcoholic coma, withdrawal syndromes, and delirium tremens. Here the physician exercises maximum control in the decision making and doctor-patient relationship. It is entirely appropriate to these clinical situations; the physician does not hesitate and takes full responsibility for his endeavors, while the patient is relatively passive.

A second type of relationship is that of mutual-participation. This is appropriate to those illnesses that are relatively chronic, require a lot of treatment, and are not life threatening when under control. In such illnesses as diabetes, cirrhosis, and rheumatism the doctor establishes a treatment program and the patient carries it out, checking with the doctor at regular intervals. Except for the initial treatment period, and for those times when the illness gets out of control, the patient is expected to carry out the treatment program for which he has been trained by the doctor, and to make many decisions on his own.

A third and commonly used relationship in medical practice is the guidance-cooperation type. Under it, control of the decision making process by the doctor will be somewhere between the absolute control he has in activity-passivity, and the shared control he has in mutual-participation. In guidance-cooperation, the patient is too sick, or his illness is too foreign to him to make decisions on his own, but he is not so sick that he is unable to cooperate in decision making. His judgment is not impaired, and he is capable of following directions. He is expected to fulfill the duties of the sick role by seeking competent help and cooperating with the doctors. If he does not cooperate fully, he must have sufficient reason for the doctor to accept it as a reasonable behavior under the circumstances.

THE DOCTOR'S RELATIONSHIP with the person who consistently drinks to excess may, on first contact, be of the activity-passivity type. This, as stated previously, is ideally suited for acute emergency situations. However, when the acute syndrome has been dealt with, a continuing relationship with the drinker will require a shift to either the mutual-participation or the guidance-cooperation type of relationship. In both, a considerable part of the

decision making and responsibility is shared by the alcoholic and the doctor.

Other than the treatment of the acute and chronic clinical pathological syndromes associated with excessive and prolonged alcohol intake, the management of deviant drinking behavior is largely a matter of control of consumption of alcohol or promotion of abstinence for the drinker. The physician will, in all probability, urge the patient to accept total abstinence or face the prospect of physical, psychological, or social damage. In this, he further insists, there can be no compromise. He will probably give the patient common sense advice, medications, and the offer of a continuing relationship through periodic office checks and visits.⁷ The physician has now discharged his obligation to the patient in the best manner he knows how. He assumes that the patient will now honor his duties in the illness role by following the doctor's orders! Often, however, he does not. After the alcoholic falls off the wagon a number of times, despite the doctor's conscientious efforts, the disappointment of the doctor turns to frustration, often followed by outright rejection of the alcoholic or referral elsewhere. This is the experience most commonly leading to breakdowns in doctor-patient relationships involving deviant drinkers.

In order to explain such breakdowns, the doctor must address himself to the symbolic aspects of the relationship between himself and his alcoholic patient. These are not readily apparent under the medical model, but are best described in psychodynamic terms. In the activity-passivity model, the doctor-patient relationship has some of the elements of a parent-young child relationship. The parent or physician is protective, authoritative, and fully responsible for the welfare of his charge. In the mutual-participation model, the character of the relationship is more like adult to adult, each shares responsibility. In the guidance-cooperation model, the relationship is an uncertain one; it is analogous to that which exists between adolescents and parents. It is subject to change with pendulumlike swings by the patient between dependence and independence, regression and growth, compliance and rebellion, being responsible and irresponsible.

The various roles, child, adolescent, or adult, are easily interchanged by the patient through nonuse or misuse of alcohol. It is not

uncommon for patients to change their relationship to their doctors during an illness, without asking the doctor's permission or notifying him in any way, except behaviorally; in the case of the deviant drinker this is done by resumption of deviant drinking behavior. In the adolescent-parent analogy this might be interpreted as an expression of rebellion or a desire for more dependence and protection. For the doctor, acting in his capacity as a professional, it means he has failed. He may now retreat from this condition called alcoholism and justify his actions by saying that either it is an untreatable disease, or it is not a disease and thus is outside the purview of medical practice.

THE AMERICAN MEDICAL DOCTOR has a great deal of prestige and power. This has been given to him by society because of what he does with patients through the doctor-patient relationship. Society expects much of him in return and it now expects him to do something about alcoholism, and he cannot turn his back on the alcoholic patient. The essence of the problem has to do with doctor-patient relationship, specifically with the breakdown between two persons with mutually interdependent roles who have complimentary privileges and duties. We suggest that failure on the part of the physician to fully appreciate the character of the relationship and the role expectancies is a frequent cause for breakdown. The role of the physician is easily recognized and the expectations are clear when the alcoholic patient is acutely ill; the physician must act, maybe to save the patient's life. The trouble often arises when the doctor either refuses or is unable to switch to a different model of relationship when the patient's condition is no longer acute. The activity-passivity model may not be appropriate at this stage and a guidance-cooperation or mutual-participation model may be better suited to the individual case. The responsibility for control of drinking is now shared, and the patient carries most of the responsibility regardless of his true ability to do so. No doctor can be absolutely responsible for a patient's drinking or abstinence, just as a parent cannot be responsible for every act of the adolescent. The problems doctors have with alcoholic patients may be contrasted with the problems parents have with their growing children. As adolescents grow up, they in-

creasingly meet society's expectation that they will assume responsibility for themselves; the parents' problem of responsibility for the adolescent behavior finally disappears. However, as alcoholics continue periodic drinking and society claims the sick role for them and expects the physician to look after them, the physicians' problem continues.

It is not difficult for a busy and successful physician to inadvertently assume a position of omnipotence. After all he is freely given the responsibility for life and death, and to accept such responsibility requires more than ordinary confidence in himself. He works comfortably and efficiently when given the role of an understanding, but nonetheless authoritarian figure. It is reasonable to assume that the physician's self image is to some extent consonant with his role. The alcoholic patient, however, continually threatens the physician's self image, and continually escapes from this type of relationship, when he resumes a deviant drinking pattern. These interactions have considerable implications for treatment of the alcoholic patient and require the physician to understand not only his patient but also himself.

An essential element of the doctor-patient relationship is the willingness of the physician to permit himself to be used. In taking responsibility for a patient's welfare, he automatically extends to him the privileges attached to the sick role. On behalf of society, the physician protects the patient and permits a degree of dependence through the doctor-patient relationship. In effect, the physician allows himself to be used for a therapeutic purpose, but the physician must also determine when, in his opinion, the doctor-patient relationship is being used in a nontherapeutic fashion. In the latter instance he may reject the person as a patient, and, perhaps, in opposition to society's expectation. Unlike many others who work almost entirely in programs for alcoholics, the physician must offer his services in the most economical manner to a wide range of sick people. It is to be expected that, under these circumstances, he will give only a portion of his time to unresponsive patients, and these will include many alcoholics. He may now have to face the criticism of society.

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APTP From Several Perspectives

The Concerned Colleague

THE IOWA MEDICAL SOCIETY APTP is a new avenue open to members who may be at the threshold of a personal and professional crisis. I have had occasion to invoke its services on behalf of a colleague. And, to date, even though time has been short, the results have been positive.

As probably is common, when any discussion of a problem condition (be it alcohol or whatever) occurs with a friend or local associate, there is apt to be a downgrading of the seriousness or even a denial of the existence.

However, if the local interest is great enough to cause to be summoned a concerned, volunteer physician from outside the immediate en-

vironment, the potential seriousness of the situation is definitely underscored. As a consequence, the troubled practitioner may receive the stimulus — or even the jolt — that's needed to get a treatment regimen started. This was our case.

In our situation no impairment of abilities was apparent. It was simply a matter of an external agent seeming to induce a growing and negative personality change. The likelihood of a damaged reputation seemed not far away. Maybe it's not conceived precisely as a diagnostic tool, but I saw the APTP as (1) a means for assessing the situation and (2) serving as an instrument of confrontation.

After one occasion I would recommend use of the APTP if the need arises with one of your colleagues. I will use it again if necessary. — *A Concerned Physician*

The College of Medicine

THE EDUCATIONAL PROCESS to help prevent impairment in physicians should start well before students receive their medical degrees. Individuals establish patterns and habits early in life. Many are fixed before entry into college, certainly by the time students enter medical school, many have experienced considerable stress and have developed methods of coping with it. If these methods of dealing with the

stresses of life are dangerous or harmful, the stage is set for health problems. Many have attempted to cope with stress using alcohol and/or other sanctioned drugs.

When persons are enrolled in medical school, they are not only learning the facts and skills needed to practice medicine, they are learning attitudes and developing lifestyles — they are becoming physicians. While in training, it is important that students evaluate their own attitudes and personal health practices. Factual information concerning physicians' health, attitudes and problems can be useful

while students are assuming their professional roles.

It is also important that students of medicine realize that impairment may take many forms. Drug dependency, especially alcohol dependency, may be a major form. A physician is impaired when personal problems or practices interfere with his or her performance as a physician. The psychosocial characteristics of some emotionally troubled physicians which can lead to alcohol and drug abuse can also lead to such characteristics as compulsiveness and rigid emotional attitudes. Such a physician is then limited in the ability to exercise judgment at the level required. Such limited ability would constitute impairment.

In addition to learning that alcoholism is a disease, medical students can come to realize that they individually are at risk and their classmates are at risk as well. Often individuals who do not have alcoholism have learned to use alcohol as a method of coping with the challenges of their daily lives. Such behavior may increase the risk of using other agents for escape as they become physicians with more

easy access to controlled substances.

Any program of prevention or indoctrination must emphasize that they as individuals are at risk and that the "problem" will not necessarily be that of someone else.

The University of Iowa College of Medicine is working with the Iowa Medical Society to create a student awareness of the issues of physician impairment. We are using a film, speakers and discussions. The program will touch on the wide variety of impairments possible: alcohol and other drugs; mental health/physical health; relationships, and work patterns.

Attention to things such as work patterns and the use of alcohol for relaxation helps promote attitudes which are at variance from those traditionally held by students of medicine and young physicians. The image of many of our students have grown up with is that physicians "work hard, play hard, and drink hard." While this has a hearty ring of "living life with gusto," it may lead to the considerable devastation so prevalent in the ranks of physicians. — *George L. Baker, M.D., Associate Dean*

The Auxiliary

AS AN AUXILIARY member and liaison for the IMS Assistance Program for Troubled Physicians, I am especially pleased this issue is devoted to this topic. An educational program is essential to eliminate the stigma that surrounds the idea of physician impairment. This is an encouragement to those physicians and families to seek help.

The IMS can be proud of its efforts to help in the treatment of troubled physicians, and importantly to preserve them for medical practice. As a spouse, I believe it important that support be given the family as needed.

The physician's wife may be the first to notice subtle indications that he is in trouble, but she is too often caught up in playing a role

— *the doctor's wife* — that demands denial of problems. She is fearful of the possible consequences to her husband's career and their lifestyle.

Getting past the denial of the problem may be difficult, but a spouse should not feel the family's lifestyle will necessarily be threatened.

Confidentiality is stressed in the Assistance Program for Troubled Physicians. Any spouse who thinks there is a need for assistance should not hesitate to call. The goal of the APTP committee is to provide and stimulate treatment without community awareness.

The American Medical Association Auxiliary has a booklet entitled, *The Family of the Impaired Physician*. It may be obtained free by writing the AMA. As the Auxiliary representative to the APTP, I would welcome any input from a spouse. Please write in care of IMS headquarters. — *Jan Richards, Algona*

DRUG THERAPY REVIEW



UNIVERSITY OF IOWA HOSPITALS AND CLINICS

REYNOLD SPECTOR, M.D., Editor

ALCOHOL WITHDRAWAL SYNDROME: PREVENTION AND TREATMENT

THE ALCOHOL WITHDRAWAL SYNDROME appears frequently and may present diagnostic confusion for the clinician. Alcohol withdrawal may complicate the course of a patient hospitalized for urgent or elective purposes. The symptoms of alcohol withdrawal may be masked by other illnesses or by drugs used for other purposes. Alcoholics may be overt or covert about alcohol consumption and clinicians must be alert to the development of the alcohol withdrawal syndrome in hospitalized patients. Alcoholic withdrawal seizures and especially delirium tremens continue to be the source of substantial morbidity and occasional mortality. Recent studies have helped to clarify several important therapeutic questions surrounding the alcohol withdrawal syndrome.

This article will describe the alcohol withdrawal syndrome and the currently available therapy.

Alcohol intoxication depends on the blood alcohol concentration, the rate of alcohol consumption, and the duration of consumption.

This information for Iowa physicians is furnished and sponsored by the University of Iowa Hospitals and Clinics.

The more rapid the consumption and the more rapid the rise in blood alcohol concentration, the greater the degree of intoxication at any particular blood alcohol level. This phenomenon may explain the desire of alcoholics to "gulp" alcoholic beverages at the beginning of a drinking episode.¹

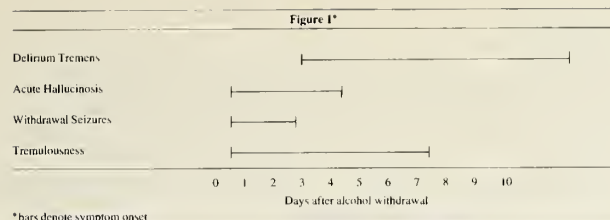
It is clear that alcoholics can ingest more alcohol than nonalcoholics to obtain a similar level of intoxication. Indeed, this is one of the major manifestations of alcoholism. Chronic alcohol ingestion may double the metabolism of alcohol, predominantly through the stimulation of the hepatic microsomal system.² However, increased metabolism of alcohol does not adequately explain the tolerance for alcohol that is observed in alcoholics. At the same level of blood alcohol, alcoholics have fewer symptoms of intoxication than nonalcoholics. This phenomenon is termed tolerance to the central nervous system depressive effects of alcohol and is not well understood. The severe toxic manifestations of alcohol (respiratory and cardiac depression and coma) appear at nearly the same blood alcohol concentration in alcoholics and nonalcoholics. These manifestations appear at blood alcohol levels of 400 to 700 mg per deciliter.

The concomitant use of alcohol and certain other drugs leads to clinically important interactions. For example, the chronic use of alcohol leads to cross tolerance to the sedative/hypnotic drugs.³

ALCOHOL WITHDRAWAL SYNDROME

The withdrawal of alcohol may produce a variety of symptoms and signs known as the withdrawal syndrome. The forms of the alcohol withdrawal syndrome are outlined chronologically in Figure 1. The forms of the alcohol withdrawal syndrome that are frequently seen include: tremulousness, seizures, acute hallucinosis, and delirium tremens. Any of the features may be mild, moderate, or severe in intensity, except delirium tremens which is always a serious illness. The likelihood of developing a serious form of alcohol withdrawal increases with the quantity and duration of drinking.⁴ Generally, at least one-and-one-half to three months of steady drinking of 500 ml per day of whiskey or equivalent is a necessary prerequisite to the development of the alcohol withdrawal syndrome.

Tremulousness may appear within a few



hours of reducing or stopping alcohol intake. The tremors are initially mild and later become more severe. They are readily stopped by resumption of alcohol intake. Anxiety, nervousness, agitation, disorientation, and hyperventilation may later appear. The spectrum of severity is very great for these symptoms. Five or six days may elapse before the symptoms subside, assuming that delirium tremens does not occur and that alcohol intake has not resumed. Most cases of tremulousness will subside spontaneously without therapy. However, progressive worsening of agitation, confusion, and tremulousness followed by hyperthermia may herald delirium tremens.

Alcoholic seizures (rum fits) are the most predictable feature chronologically. They nearly always occur from 12 to 60 hours after stopping or reducing alcohol consumption. The seizures are generalized (grand mal) and may be multiple. With proper treatment, alcoholic seizures are relatively uncommon events. A study of 200 alcoholics with no previous seizure history and undergoing withdrawal reported that no seizures occurred in patients treated with phenytoin and chlordiazepoxide or chlordiazepoxide alone.⁵ Even among alcoholics with a prior seizure history, only 15% had seizures while undergoing withdrawal.⁶ Seizures are not, therefore, a consistent feature of the alcohol withdrawal syndrome.

Delirium tremens is the most serious expression of the alcohol withdrawal syndrome. It is manifest by increasing confusion, agitation, hyperthermia, and evidence of sympathetic overactivity including tachycardia, sweating, tachypnea, and mydriasis. The onset of delirium tremens (DT's) may be as early as 24 hours or as late as 12 days after alcoholic withdrawal. Once the syndrome is fully manifest, resumption of alcohol intake will not completely suppress the signs and symptoms. The DT's may last for up to a week or longer but usually last 3 to 4 days. Mortality in the DT's is related to the complications of the

illness including aspiration pneumonia, dehydration, and circulatory collapse.

Hallucinations frequently accompany the alcohol withdrawal syndrome. Visual hallucinations are more frequently experienced than auditory hallucinations. Hallucinations may appear at any time in the course of the alcohol withdrawal syndrome. Hallucinations must be distinguished from acute hallucinosis, a separate entity manifest primarily by visual and/or auditory hallucinations. Acute hallucinosis consistently appears during the first few days of alcohol withdrawal and does not portend the development of delirium tremens. The hallucinations may be threatening or frightening to patients, requiring careful staff surveillance to avoid self-injury by the patients.

A separate but frequently related problem complicating the alcohol withdrawal syndrome is the Wernicke-Korsakoff syndrome which is characterized by confusion, ataxia, and ocular palsies and is seen only in steady drinkers. It is caused by thiamine deficiency and is due to the combination of poor dietary intake and alcohol-induced thiamine malabsorption. The Wernicke-Korsakoff syndrome may appear with intravenous infusions of glucose or with the feeding of the alcoholic.

There are frequently multiple other problems that accompany the alcohol withdrawal syndrome which require careful evaluation and therapy. These include infections, head trauma, hypomagnesemia, hypophosphatemia, and hypoglycemia.

THERAPY

The therapy of the alcohol withdrawal syndrome can be conveniently divided into two parts: preventive therapy and active therapy. Recent controlled clinical trials have clarified the role of specific drugs in the treatment and prevention of the alcohol withdrawal syndrome and the Wernicke-Korsakoff syndrome.

Prevention of delirium tremens may be accomplished by the use of several agents but the benzodiazepines are the most efficacious and have the least complications.⁷ The phenothiazines and antihistamines have no place in the prevention or treatment of alcohol withdrawal. Phenothiazines potentiate seizures and increase the complications of alcohol withdrawal.⁷ Antihistamines are not superior

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to placebo.⁷ Three benzodiazepine drugs have been extensively evaluated: chlordiazepoxide, diazepam, and oxazepam. Convenience of administration, cost, and safety generally support the use of diazepam over the other two benzodiazepines. The benzodiazepines should not be given intramuscularly because of erratic absorption. Preventive therapy with benzodiazepines should be instituted promptly when tremulousness, agitation, hallucinations, or fever appear in the course of alcohol withdrawal. Diazepam may be given orally or intravenously. Diazepam may be given in 5 to 10 mg increments intravenously every 5 minutes until a calm state is achieved. Thereafter, the same dose may be repeated orally or intravenously at intervals necessary to maintain the calm state. Chlordiazepoxide may be administered in a similar fashion but doses of 100 to 600 mg per day are usually necessary. After the first day of therapy, the doses of diazepam or chlordiazepoxide should be reduced by approximately 25% per day to avoid buildup of active metabolites and subsequent progressive sedation. Oxazepam, a metabolite of diazepam, does not cause progressive sedation because it is metabolized to an inactive compound. Oxazepam may be given by the oral route only.

Prevention of alcohol withdrawal seizures has been the topic of recent controlled trials.^{5, 6} It is clear that prophylactic anticonvulsant therapy of alcoholics with no previous seizure history is unnecessary.⁵ Alcoholics with a previous history of seizures (alcohol related or not) are at an increased risk of recurrent seizures during alcohol withdrawal but the risk is not great.⁶ Phenytoin is clearly efficacious in preventing withdrawal seizures.⁶ We recommend the use of phenytoin 300 mg daily in addition to a benzodiazepine for alcoholics who are undergoing withdrawal and who have a previous history of alcohol-related seizures. Chronic therapy with phenytoin is unnecessary in this group of patients. If a history of seizures unrelated to alcohol withdrawal is obtained, then a loading dose of 10 mg/kg of phenytoin should be given, followed by a maintenance dose of 300 mg/day. Chronic anticonvulsant therapy should be considered in this group of patients. Benzodiazepines should be administered as described above during the acute phase of alcohol withdrawal.

Prevention of the Wernicke-Korsakoff syn-

drome may be achieved by administering thiamine 100 mg intravenously or intramuscularly prior to the administration of any metabolic substrate. Oral multiple vitamins and thiamine are recommended during the recovery phase of alcohol withdrawal in order to avoid further depletion of water-soluble vitamin stores.

Delirium tremens is a medical emergency and should be treated intensively with adequate support staff, a quiet room, restraints as needed, adequate hydration and sedatives. Sedatives should be administered intravenously to achieve and maintain a calm state. Very high doses at frequent intervals may be necessary. A controlled clinical trial has established the superiority of diazepam over paraldehyde in the treatment of delirium tremens.⁸ Diazepam was superior in the control of symptoms, in decreasing the complication rate, and in ease of administration. We strongly favor its use over other agents.

Seizures appearing in the course of alcohol withdrawal may be single or multiple. Diazepam should be used to treat multiple seizures but it is not clearly effective in stopping the seizure activity. Repeated seizures should be treated initially by diazepam followed by an intravenous loading dose of phenytoin (10 mg/kg). Maintenance phenytoin should be continued during alcohol withdrawal.

The symptoms of acute hallucinosis may be controlled by the use of haloperidol 1 to 2 mg IM as needed, in addition to sedation and supportive therapy.

In summary, the rational use of the benzodiazepines and, where indicated, phenytoin are effective therapy in the prevention and/or treatment of the alcohol withdrawal syndrome. — George Everett, M.D., Instructor in Medicine, U. of I. College of Medicine

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VOX DOCS

Here's what several Iowa physicians had to say when queried as to their possible use of the IMS Assistance Program for Troubled Physicians. The full percentage tabulation for the question asked in the September JOURNAL is indicated below.



"Sometimes best friends are the last to become truly concerned." — *D. C. Young, M.D., Des Moines*

"I hope my colleagues will arrange such help for me if the need arises." — *J. W. Olds, M.D., Des Moines*

"I have had an occasion in the past to make such a contact and feel that the physician was helped by the program." — *A. M. Dolan, M.D., Waterloo*

"I feel that a guarantee of confidentiality is critical to success of the program. Professional pressure can be very motivating for treatment." — *Loren Olsen, M.D., Ames*

"Far too long we have watched our colleagues suffer. Help is available. We must not stand idly by and let tragedies occur." — *R. E. Donlin, M.D., Harlan*

"Yes, I would welcome the opportunity to be of help (hopefully). Intervention is often difficult but very important." — *A. J. Stueland, M.D., Mason City*

"I believe the Assistance Program for Troubled Physicians is not only a great advocacy program on a strict confidential basis, but in the long run probably has a great preventive application in quality of care and cost effectiveness." — *Hormoz Rassekh, M.D., Council Bluffs*

"Consider the alternatives? Do nothing and it is unprofessional; inform the Board of Medical Examiners and the physician may not get a chance to be treated before losing his license with subsequent damage to his practice and good name." — *John Clancy, M.D., Iowa City*

"It is our duty and privilege to help each other. I'm terribly impressed with the care and sensitivity used in setting up this program. If I need help, I hope it comes via this mechanism and not from the non-medical sector." — *R. D. Whinery, M.D., Iowa City*

"It should be imperative. We in the healing profession should be the first to intervene rather than wait for the inevitable disaster. If a patient had a similar problem most physicians wouldn't think twice before intervening." — *Steve Eckstat, D.O., Des Moines*

WOULD YOU REFER TO THE APTP?

We asked in September, if circumstances suggested the need, would you be inclined to arrange for a physician colleague encountering problems to be contacted for help through the Iowa Medical Society Assistance Program for Troubled Physicians? The affirmative response was almost total.

YES, I WOULD MAKE SUCH A CONTACT	94%
NO, IT'S UNLIKELY I WOULD INITIATE A CONTACT	3%
I DON'T KNOW	3%



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THINGS YOU SHOULD KNOW

LIABILITY INFO

Including a 20% premium increase to become effective 2/1/82, the IMS/Aetna Liability Insurance Program will have seen a 5-year rate hike of only 23%. Need for the added premium was announced September 16 as part of the 1981 annual report to the IMS Executive Council. Approval was given at that time to a new Investment Income Sharing Plan which will return 50% of the premium income interest to the insureds. The 1982 premium jump results from a deteriorating claims picture.

NURSING ACTIVITY

Rules proposed recently by the Iowa Board of Nursing would allow the designation Advanced Registered Nurse Practitioner for RN's meeting specified requirements. The draft rules cover the nurse anesthetist, the nurse midwife and pediatric nurse practitioner. Input on the ARNP proposal has been invited by the Board of Nursing. The IMS has furnished its views, stressing that nurses providing care in an expanded role must do so under physician supervision inasmuch as physicians retain final responsibility for patient care. The Nursing Board will take the matter up again October 29/30.

STATEMENTS APPROVED

The administration of anti-neoplastic drugs and telephone orders are covered in joint statements developed by the IMS and the Iowa Nurses' Association. The language was okayed September 16 by the Society Executive Council.

ACCEPTS AWARD

IMS Past-president Ralph Wicks, M.D., was in Des Moines September 16 to accept the 1981 Merit Award. Announcement of the award was made at the IMS House of Delegates in May.

HEALTH PLANNING

The diminishing role of the federal government in health planning was considered at length September 16 by the IMS Board of Trustees. The Board is urging conscientious, stepped-up involvement by the medical profession in local, voluntary HP activity. Based on thoughts emerging from the Society's Committee on Health Planning, the Board is advocating the IMS aid in providing information, resources and strategy suggestions to component societies working at the community level.

WELL-ELDERLY CLINICS

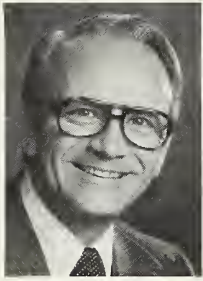
State-funded well-elderly clinics will be required to provide more detailed reporting, R.D. Eckoff, M.D., SDH official, told the IMS Committee on Aging and Chronic Illness August 27. These programs will be asked to document their compliance with the 1978 Standards and Recommendations for Well-Elderly Screening Clinics. Particular emphasis is to be on documentation of physician referral and follow-up. These actions respond to the urging of the 1981 IMS House of Delegates.

EMERGENCY SERVICES

IMS policy was reaffirmed September 16 when the Executive Council considered a recommendation of the Society's Committee on Emergency Medical Services that all EMT-A's be certified and all ambulance and rescue squad services be authorized by the state. State legislation now drafted covering these requirements has a 3-year lag between enactment and enforcement.

MEDICAID EVALUATION

Iowa Medicaid may undergo significant restructuring in the year ahead, members (including the IMS) of the Medical Assistance Advisory Council were told September 9. Federal funding cutbacks combined with state operational options make Title XIX alterations quite possible. Medicaid is an area being examined by the Governor's Commission on Health Care Costs. As of 8/15/81, a Medicaid deficit of \$8.9 million was projected for FY 1982.



COMMENTING EDITORIALY

MARION E. ALBERTS, M.D.
SCIENTIFIC EDITOR

"BURN-OUT" A "COP-OUT"?

WE HEAR more and more about "burn-out." It is described as a state of fatigue or frustration brought about by strong devotion to a cause, or a way of life, or a relationship that failed to produce the expected reward. The "burned-out" person is said to have reached a state of emotional, mental and physical exhaustion. The victim feels hopeless and helpless. Chronic fatigue produces a negative lifestyle.

Our lives become an endless merry-go-round. We are urged to seize every moment, look at it, try it on, exhaust it and hold on to it until there is nothing left of it. We live in a world of want and desire, but unfortunately in exact economic terms we overshadow our true needs with unnecessary wants and desires. We are pushed often beyond our capacity in pursuit of glittering desires.

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In past days, when our states were becoming united, the needs of life and the pursuit of happiness were foremost. Our driving motivation was to develop settlements and govern them for the good of all. Life has become more complex as we strive onward in quest of the moon and other planets. In medicine we search for new and wonderful types of therapy. We seek the tools to ply our diagnostic acumen even further. Peter Mere Latham (1789-1875) said, "The older we get, and the more conversant we have become with diseases, patients and remedies, the more stress do we find ourselves laying upon a man's constitution." Stress and its consequences are not new, but often our responses change with the times.

It would appear to avoid "burn-out" persons under stress must learn to recognize the danger signs and then acquire the safeguards to help in coping with this manifestation. The

"Short term goals must be set. Constructive approaches must be devised and flexibility must be practiced."

individual must examine himself to understand how he already is coping with his life-pattern. Short term goals must be realistically set. Constructive approaches must be devised and flexibility must be practiced. Vulnerabilities must be acknowledged for there is a limit to everybody's energy. A good insight into the entire problem was offered by Sir William Osler when he observed, "Things cannot always go your way. Learn to accept in silence the minor aggravations, cultivate the gift of taciturnity and consume your own smoke with an extra draught of hard work, so that those about you may not be annoyed with the dust and soot of your complaints."

Like the beer advertisement says, "You go around only once." So our attitudes about life need to be realistic, as do our goals. Let not a "burn-out" be a "cop-out," for life is too beautiful to cast it all aside for fleeting moments of false success. Perhaps as we age we can more easily demonstrate that genius consists of the power to apply the originality of youth to the experience of maturity. Isn't life much too beautiful to "cop out" or "burn out?"

— M.E.A.

CARCINOEMBRYONIC ANTIGEN

MEASURING THE LEVELS of carcinoembryonic antigen (CEA) in the blood of persons afflicted with colorectal cancer is considered the best noninvasive technique for monitoring the disease after surgery. More studies are necessary before routine use of CEA monitoring can be recommended for other types of cancer.

A National Institutes of Health Consensus Development Conference (Sept. 29-October 1, 1980) recommended CEA should be measured in colorectal cancer patients before surgery, and again 6 weeks after surgery. Within 6

weeks after surgery previously elevated levels of CEA should return to normal limits; failure to do so would indicate continuing presence of cancer. Thus, the course, treatment and prognosis of the cancer can be monitored.

It was emphasized that small amounts of CEA may be present in the circulation of a healthy person. Moreover, CEA levels may rise from smoking, benign tumors and inflammatory disorders. Also, 15-20% of patients with proved cancer never have increased CEA levels. Thus, CEA assays are not to be used for cancer screening, nor for diagnosis of cancer. The usefulness of CEA in monitoring patients with other types of cancer is less convincing than it is for colorectal cancer. Future research is indicated.—M.E.A.

ALCOHOLISM, DILEMMA OR DISEASE

(Continued from page 425)

ALCOHOLISM is something more than a medical matter, it is also among other things a social, moral, and legal concern. As such, the management and control must be shared by the representatives of these institutions. Labeling alcoholism a disease does not make it immediately amenable to medical approaches, nor does it make it the sole responsibility of physicians. While physicians will treat what they consider to be the medical aspects of alcoholism, they are reluctant to step out of their customary roles and relationships in an effort to meet the multiple needs of the alcoholic patient. These may include emotional support, psychotherapy, education, marital counseling, job training, employment, financial support, and a variety of other measures before the patient attains a state of sustained sobriety. Without such services, medical treatment of the acutely ill alcoholic patient becomes nothing more than a hospital revolving door, through which the patient is admitted and discharged many times. Until adequate auxiliary and rehabilitative services are developed for the alcoholic patient, the physician is going to remain the scapegoat for society's collective guilt and omission. The need for such services has long been apparent, but the provision of them has rarely gone beyond political plans and promises.

If the alcoholic is to be rehabilitated, he will need medical services. The stigma attached to alcoholism, a low level of public interest, and traditional reluctance by physicians to get too involved, except in the acute treatment of the patient, have all tended to create unfavorable hospital admission policies for alcoholic patients. Hopefully these days are going and the medical needs of the alcoholic can now be provided for within the framework and facilities for medical care. The alcoholic patient will, however, in addition require a variety of other services now nonexistent or poorly coordinated. Physicians cannot be expected to provide comprehensive and total rehabilitative services; the most they can do is to refer the alcoholic at the appropriate time to these service agencies. It is past time for scapegoating the physician, and it is now time to launch a massive program to educate other personnel to help rehabilitate the alcoholic with whatever services are necessary.

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OUR MAN ON EDUCATION

RICHARD M. CAPLAN, M.D.

CAN ART BE CME?

AFTER THE DAY'S activities of the IMS scientific program had ended, I walked to the Kansas City Museum of Art and roamed willy-nilly among its splendid collection. The more one does that, the more satisfaction it brings (in contrast, perhaps, to eating popcorn or mowing the lawn). As usually happens to me at a museum, I began to make certain "medical" observations about the people depicted in the art objects, or those strolling the galleries and corridors. This time I decided to give my visit over to the noticing of these medical phenomena. So intent did I grow upon it, and so instructive did it seem, that I began seriously to wonder if I shouldn't claim continuing education credit for what I was doing. I decided I could offer a decent defense for so thinking: at its essence, a concentrated experience of training oneself to be a good observer.

Surely no one doubts that being attentive to a patient's appearance, words and manner is the crucial first step in establishing the doctor-patient relationship and also the diagnosis. That's why we teach it (or we think we do) at the medical student's earliest contact with patients. But, alas, we then forget about it. And just as with any other skill, it requires reinforcement. Surely, as we meet patients in the course of our daily work, we can look at them closely, and be as sharp-eyed and analytical about our observations as any Sherlock Holmes. And yet most of us, I fear, grow cal-

loused or indifferent. To gaze closely at paintings, prints or statues in the museum provides, through its admitted unreality, a freshness, an awakening of the senses and the spirit of attending that may have grown dull through the pattern that most of us call routine. Artists have long recognized that although art is not reality, its ability to make us look with a full concentrated looking, leads us to a heightened awareness and appreciation of reality. And if we roam the galleries alone (even if there are swarms of anonymous viewers roaming around us) we come to experience what Thomas Mann described in "Death in Venice": "Solitude gives birth to the original in us, to beauty unfamiliar and perilous — to poetry." (In fairness, though, I need to repeat his next, and likewise true sentence: "But also, it gives birth to the opposite: to the perverse, the illicit, the absurd.")

Medieval painters sometimes depict reality with certain distortions, perhaps for emphasis, as with the fascinating bodily elongations of El Greco. But maybe their models were physically flawed, and the painters were being precisely representational? Clearly, one painting of madonna and child could properly have been called "Atopic Woman with Hydrocephalic Child." Another version of the Christ-Child seemed modeled by a poorly nourished baby with undoubtable rickets and microcephaly. Since those artists had excellent eyes and hands, how then can we account for the sandaled foot of a saint in which the toes were all precisely the same length, the great toe no greater than the others — surely no human model was ever constructed thus! Or how explain the lapse of biblical accuracy when the young Jesus, playing with St. John, is shown uncircumcised? Or how explain that Renaissance lute and recorder are being played as accompaniment to Renaissance-attired shepherds adoring the Christ-Child.

The tints of "flesh" beguile the eye — pale cream, sometimes with a suffusion of red for the tip of an alcoholic's nose, or the green or grey used to inform us that a figure is dead. Another model must "surely" have had argyria, so blue-grey the skin. The meaning is clear when limbs are wrapped in bandages, with canes and crutches nearby. Do we suspect that doubting Thomas must have been dipping his finger into arterial blood, so bright red the

(Please turn to page 441)

Dr. Caplan is Associate Dean for Continuing Medical Education at The University of Iowa College of Medicine.

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OUR MAN ON EDUCATION

(Continued from page 439)

blood in this painting? How is it the severed heads of Holofernes or John the Baptist drip blood, yet cheerful disembodied children's angelic heads show no blood while floating around the sky on small beds of wings. And

QUESTIONS/ANSWERS

(Continued from page 421)

against physicians. The number of drug and alcohol related cases has remained about the same over the last 4 years, but the number of complaints involving physician competency has increased significantly during this period. This, plus the reports from the Insurance Commissioner, constitutes the largest category of increased complaints registered with the Board of Medical Examiners.

Do you regard the IMS Assistance Program for Troubled Physicians a separate but valuable adjunct to the assigned tasks of the BME?

I believe the Iowa Medical Society Assistance Program for Troubled Physicians is probably a valuable adjunct to the work of the Board of Medical Examiners. We were advised at the time of the 1981 IMS annual meeting that 10 situations had received attention by the APTP program.

The idea of offering help to a physician (such as the APTP program does) before he/she deteriorates to the point of being restricted by the BME is good. Would you agree with this?

A physician's medical associates are likely to become aware of a possible troubled colleague even before the physician himself is cognizant of it. One of the main goals of the Board of Medical Examiners is to help in rehabilitating troubled physicians before they become a

that goiterous old lady sits unquestionably in a posture of melancholy.

Such an exercise as this, a refresher course for the skill of clinical observation, is worth its weight in gold as continuing medical education. And if I needed credit hours for my AMA/PRA application, I wouldn't hesitate to claim this time under Category 6 — "other meritorious learning experiences."

As the aphorism carved on the exterior of the museum says, "Art still has truth. Take refuge there."

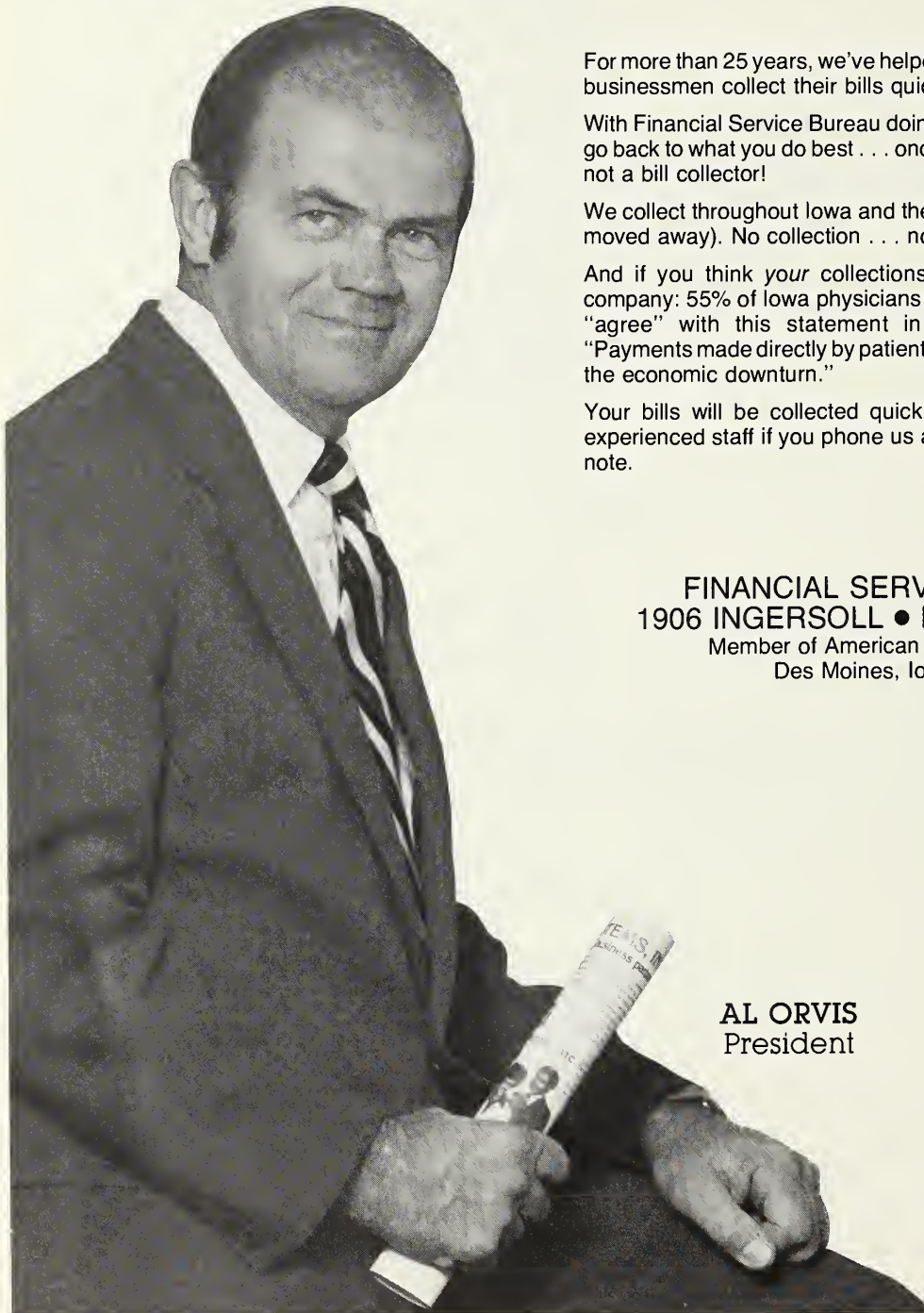
threat to themselves and the public. Therefore, an organized plan to help troubled physicians is a highly desirable activity, and we would prefer to have this handled at the local level rather than have to take formal disciplinary action against a physician.

Based on your BME experience, what comment or advice would you have for Iowa physicians as to their roles in assuming responsibility for professional colleagues who may be encountering problems that could threaten their practices?

The majority of Iowa physicians are competent, well motivated and serve the public extremely well. An occasional physician will become impaired, or potentially impaired, because of personal problems and drug or alcohol abuse. I believe physicians who know about these situations have a major responsibility to try to help and rehabilitate these practitioners before they become a more serious threat to themselves and the public. However, when it becomes apparent that they are unable to help their colleagues I believe it is prudent to refer the case to the Board of Medical Examiners. The statutory authority of the Board makes it easier for us to get physicians into a rehabilitative program, and to supervise such a program, than it is without additional help. I wish to emphasize that the probationary and rehabilitative program which the Board of Medical Examiners institutes for impaired physicians is meant to be helpful rather than punitive. The bulk of physicians who have entered this program have been significantly helped and have been able to return to free and unrestricted practice.

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A HEALTHIER AMERICA THROUGH DIET

ALL PERSONS have the right to a healthy and long life. And, fortunately, Americans are healthier today than at any time in the past. Over the years we have come to understand the cause of many diseases and consequently are better able to treat and prevent health problems. Nevertheless, there is still great room for improvement.

America does not have the lowest mortality rate of any nation in the world, contrary to what one might suspect. We rank eleventh. Each year millions of Americans die of a group of diseases known in the medical community as the "chronic" diseases. Annually, more than 10 million persons succumb to cardiovascular disease, cerebrovascular accident, hypertension, obesity-related illnesses, diabetes and cancer.

There are several interesting facts about this group of chronic diseases. First, it is evident the incidence of cardiovascular disease, obesity, cancer and the others is closely linked to the American lifestyle. We are a nation of fast food and convenience consumers. We rely on technology to replace manual labor. We exercise too little and smoke too much. Much of daily life is spent in stressful pursuit of immediate comfort without thought of consequence or planning for tomorrow. The dis-

eases mentioned here are leading causes of death only in societies as affluent and technologically advanced as our own.

Secondly, cardiovascular disease, hypertension, cerebrovascular accidents, obesity and cancer are not diseases in the traditional sense. They are not caused by any single contagious organism transmitted from one person to another, nor do they result in immediate illness at onset. Rather, they develop silently over a span of years. They are the result of a multitude of environmental factors which include stress, lack of exercise and diet. Such problems can no longer be treated effectively after the fact. Reduction or elimination of these diseases will only come with a nationwide prevention program aimed at eliminating the causes rather than the effects of chronic disease. A major component of such a prevention program would be the national diet.

Dietary surveys show Americans consume excessive amounts of fat, sugar, salt and calories. This excess comes in the form of too much meat, soda pop, alcohol and the processed foods which are high in sugar, fat and salt. Further, there is strong evidence which links these nutrients to at least six of the 10 leading causes of death in this country. Several recent reports highlight the importance of diet in maintaining health.¹⁻⁴

The report *Dietary Goals for the United States* was issued by the U. S. Senate Select Committee on Nutrition and Human Needs in 1977. Based on 50 years of nutrition research, this report details the relationship of diet to disease and sets forth six goals for improving the American diet. It is the best effort to date toward establishment of a national nutrition policy. The report recommends that if Americans want to reduce dietary risks they should:

- 1) Increase carbohydrate consumption to account for 55 to 60% of total energy (caloric) intake.
- 2) Reduce overall fat consumption from approximately 40 to 30% of energy intake.
- 3) Reduce saturated fat consumption to account for about 10% of total energy intake; and balance that with polyunsaturated and mono-unsaturated fats, which should account for about 10% of energy intake each.
- 4) Reduce cholesterol consumption to about 300 mg a day.

(Please turn to next page)

5) Reduce sugar consumption by about 40% to account for about 15% of total energy intake.

6) Reduce salt consumption by about 50 to 85% to approximately 3 gm a day.

A pamphlet for consumers was published by the U. S. Department of Agriculture and Health and Human Services in 1980. It is entitled *Dietary Guidelines for Americans* and offers very practical information for changing and improving one's diet by recommending that we all eat:

- **MORE FRUITS, VEGETABLES AND WHOLE GRAINS**
- **LESS SUGAR AND SWEET FOODS**
- **LESS SALT**
- **LESS FAT AND CHOLESTEROL**
- **WHILE MAINTAINING NORMAL BODY WEIGHT.**

Implementation of these goals and guidelines would be a very worthwhile part of a

national health plan. Unfortunately, these recommendations have become a controversial issue between government, industry and other interested parties because of the impact they would have upon the economy, agriculture, the food industry, our educational system (which presently fails at all levels to provide persons with the information and knowledge necessary for making wise food choices), and the individual. It has been conservatively estimated, however, that improved nutrition through use of these guidelines alone might cut the nation's annual health care costs by as much as \$40 billion.

In summary, there is sufficient scientific evidence to warrant a willing change in diet by many Americans. Unfortunately this information is neither being readily disseminated nor put to the most effective use. Some progress has been made at the government level in the form of goals and recommendations. However, there is great need for a concerted effort on the part of medical professionals who have direct influence on the health care of the individual. They need to educate and develop in the population a sense of personal responsibility for health. Otherwise widespread change will have to wait until such time that consumers are elsewhere informed and then finally begin to make demands on government, industry, health care providers and educators to provide the food supply and information on diet which is most conducive to our national good health. — *This material has been prepared by Gina Ries, M.S., R.D., who is with the Public Health Nutrition Section, Division of Personal and Family Health of the Iowa State Department of Health.*

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August 1981 Morbidity Report

Disease	Aug. 1981 Total	1981 to Date	1980 to Date	Most Aug. Cases Reported From These Counties
Amebiasis	7	12	8	Scott
Brucellosis	1	1	5	Tomo
Chickenpox	11	6989	7436	Polo Alto, Dickinson
Cytomegalovirus	5	18	17	Johnson, Scott, Woodbury
Eaton's Agent infection	4	19	11	Cedar, Dubuque, Hordin
Encephalitis, virol	3	14	10	Allomokee, Chickosow
Erythema infectiosum	3	1152	398	Polo Alto
Gastroenteritis (GIV)	33	12241	13487	Black Hawk, Johnson
Giardiasis	29	53	19	Polk, Johnson, Scott
Hepatitis, A	7	169	102	Linn, Muscotine, Polk
Hepatitis, B	9	60	60	Polk, Scott
type unspecified	4	41	50	Linn, Polk
Herpes Simplex	17	151	70	Johnson
Herpes Zoster	0	4	1	
Histoplasmosis	0	7	14	
Infectious mononucleosis	2	190	217	Dubuque, Johnson
Influenza, lab confirmed	0	191	109	
Influenza-like illness (URI)	414	48965	49230	Johnson, Black Hawk, Polo Alto
Meningitis				
aseptic	10	44	28	Linn, Polk
bacterial	3	86	87	Dubuque, Plymouth, Soc
meningococcal	0	18	9	
Mumps	2	18	9	Johnson
Pertussis	1	3	2	Mohosko
Robies in animals	69	634	312	Story, Plymouth, Kossuth
Rheumatic fever	0	7	0	
Rubella				
(German measles)	0	4	8	
Rubeola (measles)	0	1	20	
Solomonello	23	175	87	Scott, Black Hawk, Dubuque
Shigellosis	3	23	39	Dubuque, Monono, Scott
Tuberculosis				
total ill	11	69	61	Scott, Greene, Guthrie
bact. pos.	5	43	46	Scott, Linn, Polk
Venereal diseases:				
Gonorrhea	414	3383	3234	Polk, Scott, Black Hawk
Syphilis	2	16	14	Pottowottomie, Scott

Laboratory Virus Diagnosis Without Specified Clinical Syndrome: Adenovirus — 1, Johnson, 1, Winneshiek; Guillain-Borre Syndrome — 1, Apponose, 1, Polk, 1, Dickinson; Legionnaire's — 1, Foyette, 1, Linn, 1, Scott; Reye's Syndrome — 1, Polk; Rocky Mountain Spotted Fever — 1, Dubuque, 1, Buono Visto; Scarlet Fever — 1, Des Moines; Ascariasis — 1, Linn; Coxsackie — 1, Polk; Malaria — 1, Polk; Typhoid — 1, Scott; Compylobacter — 5, Black Hawk, 1, Dickinson, 8, Dubuque, 1, Hamilton, 2, Johnson, 2, Marshall, 1, Muscotine, 5, Polk; Toxic Shock Syndrome — 1, Worth.

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WILLIAM C. KEETTEL, M.D. 1911-1981

(Dr. Keettel died July 28 at his home in Iowa City of idiopathic pulmonary fibrosis.)

IT IS DIFFICULT TO IMAGINE ONE who filled the traditional functions of the academic physician as broadly as did William C. Keettel. As a clinician, he had a thorough knowledge of the science of medicine and a pervasive understanding of its art as well. His diagnostic skills often seemed uncanny. He was an accomplished surgeon, specializing in difficult operations such as vesico-vaginal fistula repair.

As a scholar, Dr. Keettel contributed regularly to the literature. He wrote on an astonishingly wide variety of subjects. In obstetrics, his papers on prophylactic antibiotics and elective induction of labor stand as classics. In oncology, he did original work on peritoneal cytology and he pioneered the use of intraperitoneal radioisotopes in treatment of ovarian cancer. In endocrinology, his description of premature ovarian failure has not been improved upon. Although most of his publications centered on clinical subjects, a number of his contributions were of a more basic nature. He and Dr. James T. Bradbury, using methodology crude by modern standards, were among the first to recognize the high LH levels characteristic of the polycystic ovary syndrome. Their characterization of the endocrinology of lactation amenorrhea has been essentially confirmed by more modern analytic techniques.

But it was as a teacher that he excelled. Combining vast personal experience and thorough knowledge, he was uniquely able to simplify concepts, to identify essentials, and to recognize principles. He taught by the simplest yet most effective of pedagogical techniques — example — that the welfare of the patient transcended all else. His overriding commitment to patient welfare extended far beyond physical matters, embracing thoughtfulness, kindness, and compassion as well. In an era long before the present one of sensitivities to women's rights and prerogatives, he insisted on a high level of decorum and respect. The nearest anyone ever saw him come to anger was when a resident or student failed to meet this standard.

A specific measure of his effectiveness as a teacher is provided by the large number of those who under his tutelage were led into academic careers, including no fewer than seven who now serve as chairpersons of medical school departments.

Honors and recognition, never sought and undoubtedly accepted with a touch of embarrassment, came to him in abundance. He received the honorary doctor of science degree from the University of Nebraska in 1972 and the distinguished service award of the American College of Obstetricians and Gynecologists in 1981. Medical school classes honored him as *Teacher of the Year* in 1954, 1962, 1973 and 1976.

He was a member of all of the discipline's prestigious societies and he held high office in many of them. He headed the American Association of Obstetricians and Gynecologists, the Central Association of Obstetricians and Gynecologists, and the Association of Professors of Gynecology and Obstetrics. He had a major role in shaping obstetrics and gynecology nationally as a director of the American Board of Obstetrics and Gynecology for more than 10 years and as chairman of the Residency Review Committee. There is reason to believe that other and even more prestigious positions were declined because of his fear their obligations might interfere with what he clearly regarded as his primary responsibility.

Beneath a gentle, kindly and somewhat folksy manner lay an intellect of the highest order. He was a keen judge of people, recognizing quickly their abilities and aspirations and their expectations of themselves. His advice and counsel were sought by many and they were invariably given in a thoughtful and perceptive manner.

It is doubtful if any other name in contemporary American obstetrics and gynecology is as respected, admired and revered as that of William C. Keettel. Yet his ultimate loyalty was always to his adopted State and University. During his tenure as a faculty member at the University of Iowa, 126 residents received specialty training in obstetrics and gynecology, many of whom practice in Iowa. More than 4,000 Iowa medical graduates benefited from his uniquely effective style of teaching. It is these, and the care they render to their patients, which represent his legacy. — ROY M. PITKIN, M.D., IOWA CITY.

ABOUT IOWA PHYSICIANS

NEW DOCTORS IN IOWA

Dr. George Kappos recently joined the Ankeny Medical Clinic. Dr. Kappos received the M.D. degree at U. of I. College of Medicine and completed his family practice residency at Iowa Lutheran Hospital in Des Moines. . . .

Drs. Jay C. Heitsman and **Andrew W. Walter** recently joined **Dr. Stanley Levine** at the Ottumwa Clinic to practice pediatrics. Both physicians received their M.D. degrees and served their pediatric residencies at the U. of I. College of Medicine. . . .

Dr. Richard T. Ameln recently opened a dermatology practice in Ottumwa. Dr. Ameln received the M.D. degree and completed his dermatology residency at the University of Missouri at Columbia. . . .

Dr. Keith Rutfcorn recently joined the emergency room staff at Schoitz Memorial Hospital in Waterloo. Dr. Rutfcorn received the M.D. degree and interned at the U. of I. College of Medicine. . . .

Dr. Garold Moyer has joined **Dr. William J. Schulte** in family practice in Keokuk. Dr. Moyer received the M.D. degree and completed his family practice residency at the U. of I. College of Medicine. . . .

Dr. Kenneth Burkhart and his wife, **Dr. Tressa Wilcox**, joined the medical staff at the Atlantic Medical Center in July. Dr. Wilcox is the daughter of Dr. and Mrs. Dwaine Wilcox of Atlantic. Both physicians received their M.D. degrees at U. of I. College of Medicine and completed their family practice residencies at Methodist Hospital of Indiana.

Dr. Leopoldo E. DeLucca, **Dr. Dean J. Fondahn** and **Dr. Robert J. Weatherwax** recently joined the Fort Dodge Medical Center. Dr. DeLucca received the M.D. degree and completed his otolaryngology residency at Jefferson Medical College of Thomas Jefferson University,

Philadelphia. Dr. Fondahn received the M.D. degree and completed his urology residency at Creighton University in Omaha; Dr. Weatherwax received the M.D. degree at Wayne State University in Detroit and completed his orthopedic surgery residency at Madigan Army Medical Center in Tacoma, Washington. . . . **Dr. William Heidenreich** recently began the practice of radiology at Veterans Memorial Hospital in Waukon. Dr. Heidenreich received the M.D. degree at Yale University School of Medicine and had his internship and residency at the University of Chicago. He is a diplomate of the American Board of Radiology and the American Board of Nuclear Medicine. . . . **Dr. James Bloom** and **Dr. Paul Royer** recently began family practice in Charles City. Dr. Bloom joined **Drs. H. A. Tolliver** and **Donald Trefz**; Dr. Royer joined **Drs. E. E. Schmiedel** and **Paul Groben**. Both new physicians received their M.D. degrees at U. of I. College of Medicine. Dr. Bloom served his family practice residency in Mason City and Dr. Royer in Des Moines. . . . **Dr. Robert**

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M. Kuhl has joined the Creston Medical Clinic. Dr. Kuhl received the M.D. degree at U. of I. College of Medicine and served his surgery residency at Iowa Methodist and Broadlawns Medical Centers in Des Moines. Dr. Kuhl plans to continue on the teaching staff at Iowa Methodist Medical Center.

Dr. Joseph E. Rose, Grundy Center physician for 50 years, has closed his medical practice. Dr. Rose received the M.D. degree at U. of I. College of Medicine; interned at Marine Hospital in New Orleans, La., and began medical practice in Grundy Center in 1931. He is a past president of the Grundy Center Memorial Hospital staff; Grundy County Medical Society; Grundy Center School Board; Grundy Center Community Club and Rotary Club. A longtime supporter of the Boy Scouts, Dr. Rose has the coveted Silver Beaver award. . . . **Dr. Richard A. Young**, Clarion, has been named secretary-treasurer of the Wright County Medical Society. . . . **Dr. Horst Blume**, Sioux City neurologist/neurosurgeon, gave two presentations at the 8th meeting of the World Society and 5th meeting of the European Society for Stereotactic and Functional Neurosurgery in Zurich, Switzerland. Dr. Blume covered two treatment concepts: (1) the common headache at the head-neck junction treated with radio-frequency denervation, and (2) the treatment of intractable low back and leg pain after failed back surgery using wire electrodes in the spinal canal to control pain. A third paper involving the treatment of low back and leg pain with low back disc surgery and a special type of fusion was presented at the 7th International Congress of Neurological Surgery in Munich, Germany. This presentation was based on 216 cases and randomized lumbar computerized tomography follow-up.

The Conference Room in the University of Iowa's Health Sciences Library will be named after **Dr. Robert Hardin**, professor of internal medicine. Dr. Hardin served the University as vice president for health affairs from 1964 to 1975 and dean of the College of Medicine from 1962 to 1970. . . . **Dr. H. W. Berthelsen**, Rock Valley, retired from medical practice in August. Dr. Berthelsen located in Rock Valley in 1964. . . . **Dr. Richard M. Caplan**, associate dean for Continuing Medical Education and professor of dermatology at the U. of I. Col-

lege of Medicine, has been elected president of the Society of Medical College Directors of Continuing Medical Education. Dr. Caplan spoke on "What Deans Are Worrying About These Days," at the annual meeting of the American Dermatologic Association in Banff, Alberta, Canada. . . . **Dr. Steven H. Schurtz**, Mason City, was guest speaker at a recent meeting of the Wright County Medical Society. Dr. Schurtz's topic was "Testicular Tumors." . . . At the annual meeting of the Blue Shield board of directors, the following Iowa physicians were recognized — **Dr. Robert C. Larimer**, Sioux City, was presented a service award for his 20 years on the board; 15-year service awards were presented to **Dr. Willis K. Dankle**, Clear Lake; **Dr. Enfred E. Linder**, Boone; **Dr. Edwin A. Motto**, Davenport and **Dr. John Rhodes, Sr.**, Pocahontas; a 10-year service award was presented to **Dr. Jackson D. Ver Steeg**, Des Moines; 7-year service award to **Dr. Emmett B. Mathiasen**, Council Bluffs; and 5-year service award to **Dr. Ernest O. Thielen**, Iowa City. Dr. Mathiasen and Dr. Motto retired from the board.

Dr. P. Vithespongse, an associate of **Drs. Opas and Puangtong Jutabha**, Sigourney, has reopened the Medical Clinic in Hedrick. Dr. Vithespongse received his medical education in Bangkok, Thailand, and completed post-graduate work at Trumbull Memorial Hospital in Warren, Ohio, and at Jewish Hospital in Cincinnati, Ohio. . . . **Dr. John Ebensberger** recently began family practice in Greene. Dr. Ebensberger received the M.D. degree at U. of I. College of Medicine and completed his family practice residency at Mercy and St. Luke's hospitals in Davenport. . . . **Dr. Keith A. Shaw** has joined **Drs. Paul J. Laube, Luke C. Faber**, and **R. V. Mullapudi** in surgical practice in Dubuque. Dr. Shaw recently completed his surgery residency at the U. of I. College of Medicine. . . . **Dr. Robert M. Powell**, Mason City, has closed his private practice to become chief medical officer at the Mental Health Center of North Iowa. Dr. Powell has practiced psychiatry in north Iowa the past 25 years both at the center and in private practice. . . . **Dr. J. R. Paulson** joined **Dr. David Ferguson** in family practice in Grinnell in July. Dr.



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Paulson received the M.D. degree at Michigan State College of Human Medicine in Ann Arbor, Michigan. . . . **Dr. Ray Schamel**, Fort Dodge, was guest speaker at a recent meeting of the Wright County Medical Society. Dr. Schamel spoke on newer ultrasound techniques.

Dr. Jack Fickel is closing his medical practice in Red Oak and will move to Arkansas to join the medical staff at Veterans Hospital in Fayetteville. . . . **Dr. A. G. West**, longtime Council Bluffs physician, retired in September. A native of Alberta, Canada, Dr. West received the M.D. degree at Creighton University in Omaha. He and Mrs. West plan to remain in Council Bluffs. . . . **Dr. Kenton K. Moss** has joined the Kossuth Family Health Center in Algona. Dr. Moss received the M.D. degree at U. of I. College of Medicine and had his family practice residency in Davenport. . . . **Dr. Morris Benson** began family practice in Nashua in September. Dr. Benson received his medical education at the University of Calgary of

Alberta, Canada; and completed his family practice residency at the State University of New York and the University of Alberta Hospital in Edmonton, Alberta, Canada. . . . **Dr. Ralph L. Wicks**, formerly of Boone, recently was presented an honorary membership award by the Iowa Physician's Assistant Society. Dr. Wicks is a past president of the Iowa Medical Society. He was cited for his initiation of legislation establishing the PA concept in Iowa.

DEATHS

Dr. Draper L. Long, 75, longtime Mason City physician, died August 30 at a Mason City Hospital. Dr. Long received the M.D. degree at Rush Medical School at the University of Chicago. He began his medical practice in Mason City in 1934, retiring in 1977.

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In The Public Interest

Focus On Legislation



AROUND THE STATE this month and next Iowa physicians are joining their legislators to look over the health proposals available for consideration by the 1982 General Assembly.

This ambitious project involves 12 September/October/November regional briefings. They are under the aegis of the Iowa Medical Society. Their objective is to give state lawmakers and their constituent physicians a chance to visit about pending health related measures.

Who's attending? All Iowa physicians are welcome. But it's primarily for physicians in a given area who have demonstrated a particular interest in legislative contact work. And the matter of geography is of interest with the new apportionment plan taking effect with the 1982 elections.

What topics are being covered?

A booklet entitled *Where We Stand* has been prepared for distribution at the meetings. The booklet covers various health care delivery topics. Here are excerpts:

STATEWIDE FAMILY PRACTICE TRAINING PROGRAM — "The SFPTP is making substantial progress in training primary physicians. It is contributing significantly in making medical services accessible in many regions of Iowa where physician shortages have been experienced . . . the IMS commends the General Assembly for its continued endorsement of the SFPTP and urges this support to be maintained. . . ."

IOWA MEDICAID PROGRAM — "The Iowa General Assembly is in an important partnership with the state's health care providers. This partnership has furnished needy Iowans with health care for 15 years. It has worked well. In changing times the Iowa Medical Society encourages a continuation of this partnership with a maximum emphasis on providing quality care."

HEALTH INSURANCE BENEFITS — "There are several health insurance proposals now before

the General Assembly. They fall into two basic categories. First are several generally mandating all health insurance policies sold in Iowa to pay for services of certain allied health practitioners. The second group require insurance payments for treatment provided for certain specified disorders. . . . There certainly appears to be no public mandate to give these ideas the force of law. This sentiment concurs with IMS philosophy, i.e., we should retain the freedom to choose the desired health insurance benefits."

PHYSICIAN DISPENSING PRACTICES — "To place a statutory roadblock in front of the dispensing physician as he/she seeks to serve patients as effectively and economically as possible is short-sighted and to the detriment of the patients. To eliminate or restrict the right of the physician to delegate non-judgmental dispensing functions would erode the legally accepted 'hands of the physician' doctrine. These functions have long been a part of the common law. They have served to maximize access to quality care, particularly in rural Iowa."

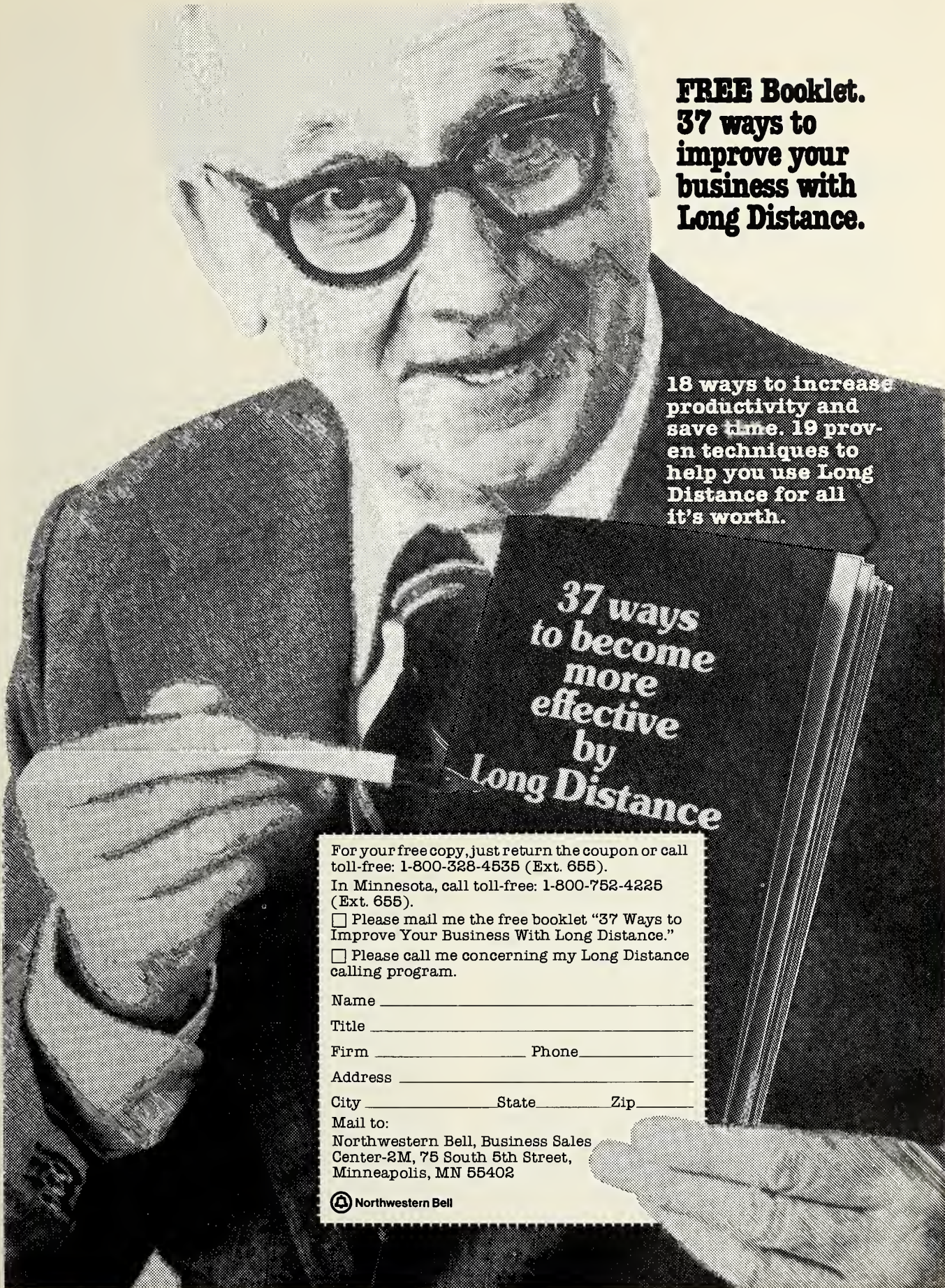
EXPANSION OF PRACTICE ACTS BY HEALTH RELATED PRACTITIONERS — "The Iowa General Assembly is requested to retain the right of physicians to determine independently and individually their referral relationships and to retain ownership and custody of their x-rays."

PHYSICIAN REFERRAL RELATIONSHIPS WITH OTHER PRACTITIONERS — The role of limited health practitioners is recognized and appreciated. Their training is generally of high quality. They are prepared and licensed to function within the scope of their training. Their roles are, however, properly limited by statute in distinct contrast to the physician. . . . The concern is over the entry of these individuals into areas where their training is limited and presents a danger to patients."

These are interesting autumn topics. Along with the normal football, hunting, etc.

October 1981

Journal of the Iowa Medical Society



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Older Iowans And Primary Health Care: Today and Tomorrow

GLENYS O. WILLIAMS, M.D.
IOWA CITY, IOWA

THE OLD have complex health problems. The effects of aging itself, as well as multiple chronic diseases which accumulate over a lifetime, make the elderly difficult to manage. Older people have more disability, make visits to physicians' offices nearly twice as often (Figure 1), have longer hospital stays, and are referred to specialists more frequently than young people.¹ In addition, many disabling conditions affecting older people are aggravated by their social situation. Most patients have some psychological, social, and functional problems, none of which can be considered in isolation. Even so, most consider themselves to be in good health, and in 1977, 82% of Iowans over 65 reported they had not been admitted to a hospital in the previous year.²

Primary health care emphasizes first contact care and assumes ongoing responsibility for the patient in both health maintenance and treatment of illness.³ Family practice, in particular, is comprehensive and includes the overall coordination of the care of the patient's health problems, whether they are biological,

Health care for older people is often complicated and time-consuming. This physician author advances some innovative ideas which she suggests may make the role of the primary care physician more effective.

behavioral, or social. The primary health care provider for elderly patients has to coordinate a mix of local medical and social support systems. Community nurses, social workers and clinical pharmacists make up the informal team which, with the physician, best meets the needs of the elderly.

Within the next 20 years, primary care physicians are going to be overwhelmed by the increasing numbers of very old patients. This population change will be dramatic and necessitate changes in practice.

BARRIERS TO GOOD CARE

In 1977, the Iowa Department of Social Services reported physician services were inadequately available in 12 of 13 responding districts, due in part to lack of physicians.⁴ Elderly people, in particular, have reported difficulty in finding physicians to accept them as patients when they move into a new community. Such patients may have to obtain care in times of crisis from hospital emergency rooms, rather than from personal physicians.

In 1977, in Scott and Cedar Counties, 38% of persons of all ages had no source of regular health care and could not identify a personal

Dr. Williams is associated with the Department of Family Practice in the University of Iowa College of Medicine. She is director of the Division of Geriatric Medicine.

THE SCANLON MEDICAL FOUNDATION/IOWA MEDICAL SOCIETY HAS DESIGNATED THIS ARTICLE
AS THE HENRY ALBERT SCIENTIFIC PRESENTATION FOR THE MONTH OF NOVEMBER 1981

physician. In addition, 50% of people over 65 had had no health care in the year before the survey.⁵ By contrast, in rural Iowa County, 91% of people over 60 had a regular doctor, 38.4% of the elderly had seen a doctor within the previous month, and 33.3% within the previous 6 months.⁶ Generalizations about this aspect of care in Iowa are not possible because of great variations throughout the state. These 2 studies show marked differences between urban and rural areas.

In 1977, health care services were considered inadequate for the low income population, which includes many elderly people.⁵ Nearly all Area Agency on Aging directors viewed the quantity of health care in Iowa as "relatively inadequate" or "deficient."⁴ Nearly half of these directors considered the quality of health services to be "relatively inadequate." Health care was also considered to be not well located, generally unavailable, and poorly utilized. Despite the increased numbers of physicians who have opened practices in Iowa during the past few years, there remain a number of small towns unable to attract physicians.

Transport. Many old people depend on friends with cars to get to the store or the doctor's office. In 31.3% of Iowa counties, which were mostly rural, the average distance to the closest primary care practitioner between 1960 and 1972 increased 20% or more. In 1972, the average distance to the closest primary care practitioner was 9 miles or more in 14 counties.⁷ Eleven percent of Iowa County residents over 60 traveled 25 miles or more for health care in 1977.⁶ Gas prices make these distances even bigger barriers to health care in 1981. Preventive health care might become a low priority under these conditions, but it has been shown that elderly people with transportation problems are more likely to use a well elderly clinic than those without.⁶

Attitudes. A service is unavailable if people do not care to use it. Welsh and Hageboeck⁴ deduced that under-utilization of available services by Iowa elderly is substantially affected by a serious problem: the perceived "negative attitude" of physicians toward the elderly. However, in Iowa County, only 5% of the over-60s questioned in 1977 thought that "doctors don't seem to care about older people."⁶

At the same time, the willingness of health service providers to change their orientation to improve services was reported as fair to poor.⁴

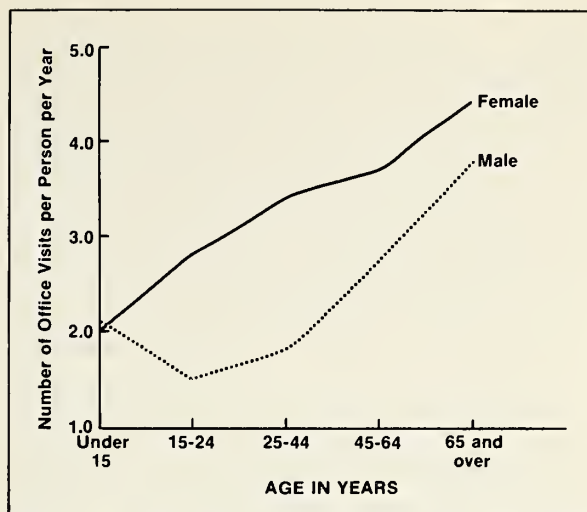


Figure 1. — Annual rate of office visits by sex and age of patient: United States, January-December 1977. Source: The National Ambulatory Medical Care Survey 1977 Summary. DHEW (PHS) 80-1795.

It has been shown that older physicians are less likely than younger physicians to see the need for, or want to utilize, supplementary health services for older patients. Such services included screening clinics, day care, day hospital, or a specialist geriatrician.⁸

Physician problems. In 1977, Iowa family physicians identified their main problems with elderly patients as 1) difficulty in communicating, 2) a feeling they had not been properly trained to treat them, and 3) a shortage of time.⁸

Characteristics of elderly people which make their health care time-consuming include multiple physical problems and the frequency of psycho-social problems. Their slowness in responding to questions in interviews, undressing, and climbing on to examining tables adds to the time required in the office. The mandatory Medicaid recertification of nursing home patients every 60 days is time-consuming, and although not often enough for some patients, it is unnecessarily frequent for others. House calls interrupt office routine, and are more often required for the old.

No significant difference in attitudes towards the elderly has been shown between young and old family physicians. Young physicians, however, are more likely to think that aged patients cannot be treated successfully, and that it is difficult to see results.⁸

(Please turn to page 466)

Reimbursement. Older Iowans represent 13% of the total population, but account for over 20% of the total personal health care expenditures. Of these, about one third is paid for privately, and two thirds are paid for by public funds (Medicare or Medicaid). Costs of health care per person in Iowa in 1976 were \$532. In the same year, costs for older Iowans were estimated to be \$834 per person.

It has been said that Medicare places the responsibility for initiating medical care on the old people themselves, and that is precisely what they are unable to do; what old people really need is a system to generate appropriate medical attention.⁹ Medicare does not cover either outreach or case-finding. But the most important deficit in the present programs, both public and private, is that coverage has been limited largely to hospital in-patient care for acute illness, rather than preventive care and health maintenance. The following services that the elderly frequently require are excluded: prescription drugs, routine eye and dental care, dentures, hearing aids, routine physician visits, immunizations and podiatry.¹⁰

HOME HEALTH CARE VS. MEDICARE

Although the Federal Government has promoted the concept of home health care, expenditure for same by Medicare in 1975 was only 1.27% of the total funds, and by Medicaid was 0.60% of total funds. However, in 1979, 158% more was spent on home health care than in 1978.

There is no general agreement that home health care is cheaper than institutional care, but there is little doubt the majority of older people prefer to stay at home as long as possible. However, the growing numbers of chronically ill and disabled persons make it difficult for service providers to respond to the demands because of lack of funds.⁵ The majority of funds are allocated for institutional care, but some people manage to live at home with the same disabilities that are found in those who are institutionalized. Organizing good home care is difficult, and can be frustrating when patient needs change rapidly and make a nursing home necessary after all.

Since the level of reimbursement for nursing home patients is inadequate, subsidization of Medicaid patients by private patients is inevitable and leads to some difficulty in finding

nursing home beds for Medicaid patients.

Reimbursement must also be claimed before it can be paid. The paperwork associated with both private and public medical insurance requires a full time clerk in a busy physician's office. The work would be simplified if a uniform claim form were used by each insurance company and by the Federal Government. Some physicians have elected not to provide help for their patients in completing insurance forms, maintaining it is not part of their job to enable patients to finance their health care. If this practice were to become widespread, elderly people in particular would have to find other sources of help with forms and obtaining reimbursement.

Drugs. In 1974, people over 65, who then comprised 11% of the U.S. population, spent \$2.3 billion on drugs, more than 20% of the national total.¹¹ Elderly people need more drugs than the young, and they are also more likely to have serious side effects and toxic reactions. Since drug costs are not covered by Medicare, this is a major burden for many, some of whom send out of state to firms which supply drugs cheaply by mail. This may delay the onset of treatment, expose them to possibly inferior or unreliable drugs, and eliminate personal attention and patient education by community pharmacists.

Patients who go to several different physicians are at risk of taking several drugs, leading at best to excessive therapy, and at worst, to drug interactions. Some patients still manage to get repeated refills without being seen, and often drugs and doses are no longer appropriate. Finally, housebound elderly patients who live where pharmacists do not have a delivery service, sometimes find it difficult or impossible to obtain their medications.

PRIMARY CARE SOLUTIONS FOR THE ELDERLY

Physician shortage. Since establishment of the Department of Family Practice at the University of Iowa in 1972, and the affiliated network of training programs, the number of family physicians in Iowa has increased. Fifty-one graduates entered practice in 1980 and 33 of these (65%) are practicing in Iowa.¹² Interest in primary care residency training is also increasing among students at the U. of I. College of Medicine, reaching 56% of the 1980 graduating

(Continued on page 467)

class. Fifty-six percent of the graduates since 1976 have chosen to practice in Iowa.

Physician problems. Increasing effort is being made in medical schools nationally to include geriatric medicine in the curriculum. In Ohio and Nebraska, medical schools are required by state law to include geriatric medicine in their curricula for all students. Questions on geriatric medicine will be included in national examinations probably within the next year. The number of continuing education programs devoted entirely to geriatric medicine have increased the past few years in response to the recognition of need.

Lack of time is a problem not yet solved. Well elderly clinics, physician extenders, public health and visiting nurses provide valuable follow-up and case finding, but more needs to be done.

PHYSICIAN EXTENDERS

Physician extenders are well accepted by elderly people,¹³ and are gaining increasing acceptance, particularly among younger physicians. Sixty-eight percent of the 144 graduates of the University of Iowa Physician Assistant program are employed by private physicians in office settings, and 77% of these are in family practice settings. Those working in satellite offices make health services more accessible to old people with transportation problems, and also free up some of the family physicians' time.

The state's well elderly clinics are run by public health nurses and nurse practitioners, and others are organized by the University of Iowa College of Nursing. A well elderly clinic is a point of entry to health care services for those persons who for financial or other reasons do not seek physical check-ups or screening from their personal physician. The clinics provide health education, health screening, referral, easy accessibility, and follow-up at low cost; fees are on a sliding scale. The Iowa State Department of Health has in its 1980-85 objectives a statement that 5-6% (30,000) of all persons over 60 should be served annually at well elderly clinic sites by 1982. Funding sources are being sought for establishing 25 additional clinics.¹⁴

Home health care is a vital part of primary care for elderly persons. The Iowa Department of Social Services has ranked home health aide service as the area in which expansion would

be most beneficial to the elderly.⁴

Accessibility of health care services has been improved by subsidized senior transport systems; these buses pick up patients at home, and take them to the doctor's office.

Drugs. Clinical pharmacists are being trained in increasing numbers, and they serve a valuable function in physician and patient education. Workshops given by University of Iowa College of Pharmacy and College of Medicine faculty are held periodically around the state.

Time limits for refills and restricted numbers of refills of prescriptions have already been instituted. Increased awareness of the problem of substance abuse among both providers and consumers, and substance abuse treatment programs for women and the elderly are among the long range plans of the State Department of Health.¹⁴

Communicable disease prevention. The State Health Plan aims at reducing the influenza mortality rate of 28.4 per 100,000 among the elderly and infants.¹⁴ In 1978, influenza occurred at a higher incidence rate than any other communicable disease in Iowa. The incidence is higher in persons 45 years and younger, but the death rate is higher in older age groups. To achieve the State goals, more elderly, chronically ill, and institutionalized Iowans must be immunized. Primary care physicians are in an excellent position to see that the present immunization rate of 10-15% of elderly is increased. The State is not able to supply free vaccine this year, but some free medical clinics provide free immunization. The cost of pneumococcal vaccine, recommended for persons over 50, is not yet reimbursed by Medicare.

Mental health. The Iowa Mental Health Authority identified the elderly as its target population for 1981. Community mental health centers are not often thought of as primary care providers, but have considerable potential, particularly if there is close liaison between centers and primary care physicians. Six centers are planning to develop programs for elderly people, and to focus on the misdiagnosis of organic brain syndrome and senility. Under the State Health Plan, community mental health centers will increase their accessibility and adaptability to needs of the elderly. At present, physicians have the advantage that

(Please turn to page 468)

they are more readily available to patients, and there is no stigma attached to visiting them.

Reimbursement. Long range recommended actions in the State Health Plan include adequate reimbursement. More extensive coverage of rehabilitation and maintenance services is proposed for Medicaid reimbursement of nursing home care. However, uncertainty prevails at the Federal level.

Paperless claims administration by Blue Shield is being tried in several Iowa physicians' offices.

FUTURE DIRECTIONS

Primary care in the traditional sense has served Iowa well, but future directions will have to be different to meet the fast-growing need.

Consider the following ideas for innovative services which could make the primary care physician's role more effective as well as easier:

1. Create community *assessment teams* of trained professionals to assist physicians in assessing the health and social needs of the old, identifying the level of care needed, and facilitating the provision of the many services which they may require.

2. Develop an outreach system of preventive medicine for the old who are not receiving medical care, especially in urban areas. One way would be to establish an age and sex register, with provision for an automatic visit and evaluation of every person when they reach, say 75 years of age. A specially trained multidisciplinary team would evaluate physical, social, environmental and financial factors, and perform this service for an area, such as a county.

The outreach system would also identify old people who are known to be at *high risk* (all old people who live alone, have locomotor difficulties, are known to be "loners," have been recently discharged from hospital, recently bereaved, or have a history of mental illness). Special follow-up of such elderly could be the responsibility either of a trained health visitor who is a member of the family physician's team, or of the community home health nurse.¹⁵

3. Provide *special inducements* through insurance schemes for physicians with large numbers of elderly patients. As an example, British

general practitioners receive a higher capitation fee for patients over 65, and even higher fees for those over 75, in recognition of these patients' time-consuming problems.

4. The following services are not generally available in Iowa, but constitute an important accepted part of established care for older people in some other countries and parts of the United States:

- a) *Day Care programs.* These provide non-medical supervision, stimulation, socialization, and activities for several hours a day. The establishment of 5 adult day care programs is recommended in the State Health Plan.

- b) *Day Hospitals* provide active treatment and rehabilitation under physician supervision for patients who do not need to be in the hospital, but for whom regular outpatient care would be less satisfactory. They sleep at home, and spend 5-6 hours at the Day Hospital receiving nursing care, physical or occupational therapy, and counseling as needed. Families are freed of responsibility during this time.

- c) *Respite care.* Families of patients being cared for at home are relieved of responsibilities for a time, such as overnight, on weekends, or during family vacations. Long term care beds are kept available for such short term use when in-patient respite care is necessary.

- d) *Health care centers* where physicians, community home health service workers and social services are housed and work closely together. This simplifies coordination of the varied services needed by old people, and encourages a team approach.

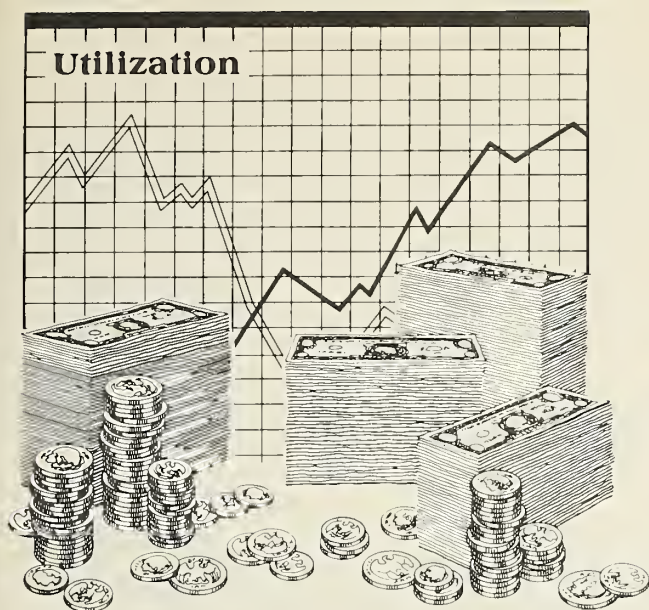
CONCLUSION

The complicated health care of old people will become more time-consuming as the numbers of the very old continue to increase dramatically.

Some modifications of the present system will be necessary to meet the fast-growing need in Iowa. More physicians, and more health professionals of all kinds, better-educated in geriatric medicine, will become available. Improved reimbursement, special emphasis on home care, and a variety of innovative services, all have great potential for improving the mental and physical health of elderly Iowans.

REFERENCES

The references noted in this paper are available either from the author or the JOURNAL OF THE IOWA MEDICAL SOCIETY.



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We encourage your support of these programs which strive to make quality health care attainable and affordable.



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Primary Needs Of the Elderly Iowan

THE NEEDS of the elderly in Iowa deserve conscientious and ongoing attention. This premise backdrops an ongoing project of the University of Iowa Committee on Aging. The project has involved compilation of a document entitled *Iowa Elderly: A Policy Report to the Iowa Legislature*, which includes recommendations for legislative action in various areas.

What follows here are condensed comments from the several statements included in this report. Each statement represents the view of a professional or group of professionals in the field under discussion.

One objective of these statements is to prompt thought and discussion. They come from different perspectives, and as such they are not expected to receive full endorsement from all providers in the related fields. Nonetheless, they represent food for thought.

DRUG MEDICATION/ELDERLY

Elderly persons are vulnerable to over-use and improper use of medications. The resulting problems may include side effects/reactions; emergence of additional illness; more frequent hospitalization; worsening of concurrent diseases, etc.

Studies of elderly patients show as many as 59% do not take prescribed medications properly. They may lack understanding of their drug regimens; they may omit doses or take too many; they may take medications not currently prescribed for them and actually intended for others. One in every 3 elderly patients may be endangering their health by these practices.

Mental frailty among the elderly creates problems in correctly following dosage sched-

Independence to the fullest extent possible is advocated for the elderly citizens of Iowa. Where health care and other support are needed it's most advantageous to have these available in the local community. This summary covers briefly various health care areas where older Iowans need particular consideration.

ules, particularly when no relative or friend is present to supervise. The infirm elderly person is especially at risk when isolation precludes adequate contact with health care team-members. In one survey noted, 7 of 8 elderly patients over 75 years were taking medications without outside assistance, with one of 3 taking more than 4 medications daily.

The greater the number of drugs a patient takes, the greater the potential for drug interactions. Polypharmacy, or the use of additional drugs, is often initiated to counteract the effects of previous drug therapy. Individuals have been reported as receiving as many as 20 different medications — with one study indicating at least a 40% chance of having an adverse reaction to one or more drugs.

In another study, 28% of the ambulatory elderly population took more than one aspirin-containing product. This duplication is potentially serious, as aspirin is the most frequent cause of drug-induced hospitalization.

HEARING-SPEECH-LANGUAGE PROBLEMS/ELDERLY

Communication limitations are more prevalent among the elderly than commonly believed. At least one of 4 persons over 65 years, 2 of 5 over 75, and as many as 4 of 5 of those in nursing homes have hearing losses sufficient to interfere with communication.

Oral communication — speaking, listening and understanding — is the primary medium for social interaction. Once this limitation emerges, the person with the disorder tends to become more isolated from society. This occurs either (1) from the person being ignored due to the difficulty in conversing, or (2) to withdrawal by the person because he/she is experiencing frustration in understanding or being understood.

The effect is a reduction in interaction, and eventual isolation. This heightens problems of keeping older citizens active, productive and integrated into society.

It is not true that everyone loses hearing with age. Three of 4 persons over 65 years, and 3 of 5 over 75, have hearing adequate for their communication needs. Many may experience a diminution in hearing acuity and sensitivity with age, but that does not equate with deafness. Help is available. Advances in hearing aid design and use, and the development of rehabilitation techniques by audiologists, help the elderly maintain adequate communications skills. Awareness of this area of health care is important for the elderly.

ORAL PROBLEMS/ELDERLY

Oral health of the elderly is a further concern. A national study has shown almost one of 2 elderly have not been to a dentist for at least 5 years — this compares with one of 7 for the balance of the population.

Chronic destructive periodontal disease is almost universal in those over 65 years. Dental disease is cumulative — unlike most body tissues, those tissues attacked by dental disease have little or no power of regeneration and, when destroyed, they must be replaced with substitute materials. Thus, dental conditions in the elderly represent problems accumulated over a long period of time.

Poor dental health is interwoven with problems of nutrition, speech, appearance and other factors which are key to maintaining an acceptable quality of life.

NURSING PERSPECTIVES/ELDERLY

One goal of nursing is to keep the aged residing in their homes at an optimum health level. Individuals tend to live longer in their own homes. Such living tends also to promote psychological and social well-being. And, eco-

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Caution: Federal law prohibits dispensing without prescription.

Description: Each Anusol-HC Suppository contains hydrocortisone acetate, 10.0 mg; bismuth subgallate, 2.25%; bismuth resorcin compound, 1.75%; benzyl benzoate, 1.2%; Peruvian balsam, 1.8%; zinc oxide, 11.0%; also contains the following inactive ingredients: dibasic calcium phosphate, and certified coloring in a hydrogenated vegetable oil base.

Each gram of Anusol-HC Cream contains hydrocortisone acetate, 5.0 mg; bismuth subgallate, 22.5 mg; bismuth resorcin compound, 17.5 mg; benzyl benzoate, 12.0 mg; Peruvian balsam, 18.0 mg; zinc oxide, 110.0 mg; also contains the following inactive ingredients: propylene glycol, propylparaben, methylparaben, polysorbate 60 and sorbitan monostearate in a water-miscible base of mineral oil, glyceryl stearate and water.

Anusol-HC Suppositories and Anusol-HC Cream help to relieve pain, itching and discomfort arising from irritated anorectal tissues. These preparations have a soothing, lubricant action on mucous membranes, and the antiinflammatory action of hydrocortisone acetate in Anusol-HC helps to reduce hyperemia and swelling.

The hydrocortisone acetate in Anusol-HC is primarily effective because of its antiinflammatory, antipruritic and vasoconstrictive actions.

Indications and Usage: Anusol-HC Suppositories and Anusol-HC Cream are adjunctive therapy for the symptomatic relief of pain, itching and discomfort in: external and internal hemorrhoids, proctitis, papillitis, cryptitis, anal fissures, incomplete fistulas, pruritus ani and relief of local pain and discomfort following anorectal surgery.

Anusol-HC is especially indicated when inflammation is present. After acute symptoms subside, most patients can be maintained on regular Anusol® Suppositories or Ointment.

Contraindications: Anusol-HC Suppositories and Anusol-HC Cream are contraindicated in those patients with a history of hypersensitivity to any of the components of the preparations.

Warnings: The safe use of topical steroids during pregnancy has not been fully established. Therefore, during pregnancy, they should not be used unnecessarily on extensive areas, in large amounts or for prolonged periods of time.

Precautions: General: Symptomatic relief should not delay definitive diagnoses or treatment.

Prolonged or excessive use of corticosteroids might produce systemic effects.

If irritation develops, Anusol-HC Suppositories and Anusol-HC Cream should be discontinued and appropriate therapy instituted.

In the presence of an infection the use of an appropriate antifungal or antibacterial agent should be instituted. If a favorable response does not occur promptly, the corticosteroid should be discontinued until the infection has been adequately controlled.

Anusol-HC is not for ophthalmic use.

Pregnancy

See "WARNINGS"

Pediatric Use

Care should be taken when using the corticosteroid hydrocortisone acetate in children and infants.

Dosage and Administration: Anusol-HC Suppositories—

Adults: Remove foil wrapper and insert suppository into the anus. Insert one suppository in the morning and one at bedtime for 3 to 6 days or until inflammation subsides. Then maintain comfort with regular Anusol Suppositories.

Anusol-HC Cream—Adults: After gentle bathing and drying of the anal area, remove tube cap and apply to the exterior surface and gently rub in. For internal use, attach the plastic applicator and insert into the anus by applying gentle continuous pressure. Then squeeze the tube to deliver medication. Cream should be applied 3 or 4 times a day for 3 to 6 days until inflammation subsides. Then maintain comfort with regular Anusol Ointment.

NOTE: If staining from either of the above products occurs, the stain may be removed from fabric by hand or machine washing with household detergent.

How Supplied: Anusol-HC Suppositories—boxes of 12 (N 0071-1089-07) and boxes of 24 (N 0071-1089-13) in silver foil strips with Anusol-HC printed in black.

Anusol-HC Cream—one-ounce tube (N 0071-3090-13) with plastic applicator.

Store between 59°-86°F (15°-30°C).
 1089G010

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nomically, studies show quality home care is less expensive than institutional care.

Contrary to popular belief, more than 9 of 10 elderly persons reside in the community and not in institutions. So, organizing community services for the elderly is important for daily living.

The prevention and early detection of disease needs ongoing emphasis. These preventive services need to be stressed to assure optimum health of the elderly. Public health nursing is of significant value here with its screening, teaching, health maintenance and other functions.

The scope of activity by community nurses is broad. It emanates from various points, including well-elderly clinics. The range of services includes hygiene, nutrition, exercise, safety, first aid, self-examinations, etc. Nurses also can serve ably as links between the aged person, his/her family and other professionals in the health and social service fields.

Studies indicate as many as one of 4 patients in skilled and intermediate care nursing facilities are there because no other alternatives are available. This underscores the value of helping the elderly sustain themselves in their home environments.

PRIMARY MEDICAL CARE/ELDERLY

Primary health care is often defined as first contact care. It assumes basic responsibility in both health maintenance and illness/disease therapy.

Health problems become complex among older people. This is due to the effects of aging; multiple diseases, many of them chronic; and psychological, social and functional problems. None of these can be considered in isolation — each has an effect on "wellness" or "illness."

Family practice medicine is community-based, with patients usually in geographic proximity. This often enables the physician to coordinate needed community services on the spot. Older patients with chronic diseases benefit from having their main sources of care conveniently located.

Health care of the elderly is acknowledged to be time consuming. The presence of multiple physical problems and the frequency of psycho-social deficits are the acknowledged reasons. It is of consequence to note that family physicians in training are being oriented to deal with these factors. They are learning the

value of participation in, and coordination of, the mix of medical/social support systems, which include the community nurse, social worker, pharmacist, etc.

PROBLEM DRINKING/ELDERLY

About one in 25 elderly Iowans may be classified as a "problem drinker." Most are men. The proportion of elderly drinkers compared to younger drinkers is quite low. The elderly drinker has fewer, less severe and different problems than younger problem drinkers. He/she is more likely to suffer from self-neglect, accidents, injuries from falling, confusion and family quarrels, but is less apt to have problems with employment, the law or physical violence. The elderly drinker is less likely to need detoxification or medical treatment for alcohol withdrawal. However, he/she may have medical problems that need to be distinguished from those related to the normal aging process.

Drinking late in life is often a reaction to retirement, loss of a spouse and feelings of loneliness. These conditions are responsive to help. Help from an empathetic community alcoholism counselor is often beneficial. Use of existing community resources and services is encouraged; institutionalization should be a last resort.

NUTRITION/ELDERLY

The poor quality of diets among many elderly persons is caused by any of several factors. Naturally, a lifetime development of good eating habits is most influential. But events in senior years, such as the loss of a spouse, often cause an abrupt change in dietary patterns. The incentive to prepare and/or secure an adequate and nutritious meal is lessened. Factors relating to this include reduced income, lack of teeth, intestinal manifestations, etc.

There is concern about the susceptibility of the elderly to misrepresentation about the need for vitamins, diet supplements, etc. The role of the health care provider in furnishing information and counsel about proper foods is important and often under-emphasized.

SUMMARY COMMENTS/ELDERLY

The preceding comments touch superficially on areas of importance to the older citizens of

(Please turn to page 487)

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Adult Day Health Care

MARIE STUDER

Waterloo, Iowa

THERE HAS BEEN a rapid growth of adult day health care centers (ADHCC) in the United States since the mid-1960s. This is indicative of the increased interest in community-based long-term care. Within a 2 year period, the Department of Health and Human Services reports a nationwide doubling of these programs. The ADHCC provides a program of ambulatory care during the day in a group setting away from home. Participants spend up to 9 hours per day, 7 days per week at the day health center, depending on their needs. Professionals and paraprofessional staff develop individual treatment plans with specific goals to meet the needs of participants.

USERS OF ADHC

The candidate for ADHC is an individual who requires services oriented to prevention, maintenance or rehabilitation. A case study is illustrative:

An 82-year-old woman was admitted to an adult day health care center following hospital discharge. She had been hospitalized as a result of repeated strokes, suffering hemiplegia and some memory loss. Her 83-year-old husband would have been unable to cope with the stress of caring for her needs at home on a full-time basis. Although his own health was adequate, he could not follow through with the prescribed physical therapy regimen; prepare three meals each day; monitor her health status in addition to maintaining their home and personal lives. At the

There are nine adult day health care centers in Iowa. They represent a relatively new approach to helping the elderly maintain a realistic level of independence. This discussion affords some insight into their workings.

day health care center, the wife receives both physical and occupational therapy; her medications are regulated and monitored; she participates in recreational activities and benefits by group socialization. Her husband is able to retain his own identity while preserving the family relationship within the home, therefore eliminating the potential of full-time inpatient care for his wife.

PRIMARY OBJECTIVES

The ADHCC can ease the transition from hospital or nursing home to the community, enabling the individual to progress toward treatment and rehabilitation goals. It can help families and caregivers who have responsibility for the impaired adult who cannot be left alone during the day, but who does not require 24-hour nursing care. The ADHCC can help functionally disabled adults and frail elders to maintain or improve their level of functioning and remain in the community to the preclusion of premature inpatient placement. Participants have the opportunity to socialize, enjoy peer support, and receive health and social services in a stimulating and supportive environment that promotes better physical and mental well-being.

INDIVIDUAL SERVICE PLANS

The development of an individual service plan is the cornerstone to effective use of the day health care program. This plan should be interdisciplinary and consider the participant's

Ms. Studer is executive director of Adults Care, Inc., and founder of the Iowa Association of Adult Day Health Care Providers.

(Please turn to page 475)

AGING WELL!



**SOME IMPORTANT IDEAS
FOR OLDER CITIZENS —**

AGING WELL!



AGING WELL

G

Good habits help!

Your teeth — Brush them regularly. It is best to brush after every meal, but once a day at bedtime is a must. Look after your dentures. Take them out at night. See your dentist once a year even if you have dentures.

Your home — Keep names, addresses and telephone numbers of these people by your phone: your nearest relative, a good friend who lives nearby and your doctor.

Don't use "throw rugs." It is easy to trip on them and fall.

Rearrange electrical appliances and lamps, so you are not likely to trip on the cords.

Put non-slip mats or stickers in the bathtub.

Keep things you use every day on cupboard shelves that are no higher than your shoulder.

Keep warm in the winter. Wear extra layers of wool clothes indoors.

Sleep — Many older people sleep less than 8 hours... this is normal.

AGING WELL

A

Aging does not —

- make you tired!
- make you constipated!
- give you a pain somewhere!
- make your bladder weak!

- make your feet swell!
- give you high blood pressure!
- make you anemic!
- make you bleed!

These symptoms are usually caused by something which your doctor can help with. Don't hesitate to ask about these or other personal matters.

If you nap during the day, you're unlikely to sleep as much at night.

Tell your doctor if you have recently become unable to sleep properly and wake up feeling tired.

Exercise can help you sleep well.

AGING WELL

I

Is your medicine really necessary?

Take **ALL** your medicines with you when you visit your doctor — prescription medicines and those you have bought yourself. “over-the-counter.”

Ask if you should be taking all of them.

Don't take medicines your own physician does not know about. Don't take medicines prescribed for somebody else.

If you're not sure you completely understand how much medicine to take, or how often to take it, ask your physician, your pharmacist, or a registered nurse.

Some people forget whether they have taken their medicines. If you put a whole day's dosage of pills in a cup in the morning you'll be able to tell whether you took a pill by counting the ones left. Ask your pharmacist for other ideas.

If you have trouble opening medicine bottles, your physician will prescribe an easy-open container.

Keep a list of your medications in your purse or wallet.

AGING WELL

N

Nutrition!

You need fewer calories today than when you were more physically active.

Every day eat some food from each of the 4 groups listed. You need good food, just less of it than you used to.

Meat Foods

Meat, fish, poultry, nuts

Dairy Foods

Milk, cheese, butter, eggs

Two servings a day are recommended from each of these groups.

Fresh Fruit/Vegetables Vegetables, fruits

Cereal Foods

Bread, pasta, rice, cereals.

Four servings a day are recommended from each of these groups.

Alcohol contains a large number of calories. You may not be hungry for the food you need if you drink too much.

Vitamins. A multivitamin tablet once a day is probably good for you. Do not buy expensive special vitamins or “health preparations” without checking first with your doctor.

Avoid extra salt. You keep a pint of extra water in your body for every extra teaspoon of salt you eat.

AGING WELL

G

Go to your doctor!

Go as regularly as your doctor suggests.

Choosing a doctor is important. Find one with whom you can talk freely about your feelings, your family and your concerns.

Take all medications with you every time you go.

Arrive early for appointments. If you're late and

flustered you may forget things you wanted to say.

Make a list of questions for the doctor.

If you don't understand the doctor's explanation, say so. It's better to have instructions written down than to try to remember everything.

Ask for a flu shot every fall, and a pneumonia shot.

Don't be afraid to tell your doctor you'd like to get a "second opinion" on what's wrong with you, or what to do about it. Your doctor should help you accomplish this.

AGING WELL

W

Walk every day!

Exercise makes you feel good — physically and mentally. Try walking, dancing, swimming.

Exercise helps you from getting stiff.

Often, the more you exercise, the more you're able to do.

If it's icy or very windy outside, use good judgment and try to exercise indoors.

Walk with a friend. Talk about the things you see and hear.

Remember, sunlight and fresh air are good for you, but wear a hat and appropriate clothing if you're

out a lot in the hot sun. Rest periodically and take a drink of water.

Exercise can help your sexual life.

Walking a flight or two of stairs may be better than the elevator.

AGING WELL

E

Enjoy yourself!

Make an effort to see your friends regularly.

Do something you've wanted to do for a long time.

Invite your neighbor for a cup of coffee.

Join something and get involved in the activity.

Try to get out of the house regularly. If you can't, call a friend.

Make plans to do something to help another person.

JOURNAL OF THE IOWA MEDICAL SOCIETY November 1981

These suggestions for older Iowans have been compiled by Glenys Williams, M.D., Iowa City, Iowa. Dr. Williams is director, Division of Geriatric Medicine, Department of Family Practice, University of Iowa College of Medicine. This Aging Well folder is part of the ongoing health education program of the Iowa Medical Society, 1001 Grand Avenue, West Des Moines, Iowa 50265. Additional copies are available on request.

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Iowa Medical Society

AGING WELL

L

Lists are useful!

Make lists of things you want to remember; they will help to jog your memory.

Make a list of helpful people so it will be ready if you need it.

Your physician's receptionist will be glad to help you with the names and telephone numbers of the Area Agency on Aging, Department of Social Services, Senior Citizens Center or other agencies.

AGING WELL

L

Learn something new!

Keep your mind young and active by learning something new each day.

Read a book. Use the library. Try **A Good Age** by Alex Comfort.

Take one of the courses offered on television.

Learn enough about something so you could start a new job, if you wanted to.

Use your common sense and seek help as you need. Your older years will be enjoyable and rewarding.

AGING WELL SUPPLEMENT AVAILABLE TO IMS MEMBER PHYSICIANS & OTHERS

The preceding 4-page special "Aging Well" supplement has been compiled by Glenys Williams, M.D., Iowa City, and the Iowa Medical Society. It is available in quantity for additional health education use. Additional copies may be placed in office reception areas or given to patients in connection with an office visit. Copies may be ordered from the Iowa Medical Society (at \$10 per 100 to cover printing costs). The order form below is provided for your convenience in obtaining additional copies.

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(Continued from page 474)

diagnosis, disabilities, mental capacity and social functioning. Interdisciplinary team members should include minimally the participant, the family, the physician, a social worker and a nurse. Based on sound assessment, the team can develop long and short term treatment goals. By assuming the team approach to service planning, a center can avert unnecessary or duplicative treatment. The ADHCC provides an entry point to other needed supportive services, can assure joint and timely evaluation, and can develop close cooperation between service professionals and participants and their families.

The individual service plan is designed to meet the nutritional, recreational, occupational and physical needs of each participant. Included are health and pharmaceutical screening, counseling, physical therapy, occupational therapy, speech therapy, audiology, therapeutic recreation, transportation, socialization, education, personal care and a hot noon meal and snacks.

Such services are often provided on contract to help assure economical use of community resources. If, for example, the multidisciplinary team develops a treatment goal for the physical restoration of the previously-mentioned 82-year-old ADHCC participant, the woman's therapist could submit a treatment plan the day center staff can implement on a scheduled basis. In this case, the therapist may assume a role on the team as the individual assessment, case planning, imple-

mentation and evaluation are carried out.

While no particular ADHCC is "typical," there are commonalities among such centers. The day health care program offers services tailored specifically for each participant. These therapeutically oriented services are directed toward prevention, maintenance, or rehabilitation. Services are then integrated into the daily program plan of the individual participant. The breadth of the individually prescribed services in the ADHCC is the distinguishing feature.

The program is most often provided in conjunction with a hospital or nursing home, as a free standing facility, or in a specialized senior center. The characteristics of clients in these settings range from those recovering from an acute illness to those whose social functioning has regressed to a point where continued independence is in question.

CONCLUSION

The adult day health care program is part of the continuum of long-term care. The provision of habilitation, rehabilitation, and maintenance services through such a program can shorten a hospital stay; can prevent or delay long-term inpatient care, and can assist the individual in making the transition from inpatient facility to the community. Adult day health care allows for both continued progress of habilitation or rehabilitation, and encourages maintenance of functional capacity, while giving families of impaired individuals relief or respite during the day.

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Every Eighth Iowan

WOODROW W. MORRIS, Ph.D.

Iowa City, Iowa

THE TITLE derives from the fact that the proportion of Iowans in the 65-plus age group is 13.1%, about one in eight. Iowa ranks high nationally in its proportion of elderly persons. In 1979, the largest concentration of older persons in the United States (i.e., 13% or more of a state's population) occurred in 6 states: Florida (18.1%), Arkansas (13.7%), Iowa and South Dakota (13.1%), and Missouri and Nebraska (13.0%).

Another way to look at the distribution of elderly persons is by numbers rather than percentages. Thus, California and New York each had more than 2 million older people, while Florida, Pennsylvania, Texas, Illinois and Ohio each had more than 1 million; and Michigan had almost 1 million. One-fourth of the country's 25 million elderly people live in just 3 states (California, New York, and Florida), and most of another fourth in the other 5 states.

Since the distribution of elderly by percentages locates the high proportions in essentially rural states, and the distribution by numbers locates the high numbers of elderly in essentially urban states, it is important to take both percentage and number distributions into account when considering the relative impacts of the elderly in rural and urban places.

At the latest count there were about 380,000 Iowans in the 65-plus age group. In terms of percentages, the largest concentrations (16.9% or more) occurred in 20 counties, shown in

Statistics presented here confirm the high percentage of elderly Iowans to total state population. Indicated as well is the utilization of health care services by the elderly, as well as the comparative sums spent for these services.

Figure 1. These are essentially rural counties, only one of which includes a city with a population greater than 8,000 (Creston, population 8,234). Thirteen of these counties are among the 21 which comprise the lower 2 tiers of counties along the Missouri border. These counties will be referred to later as the *rural counties*.

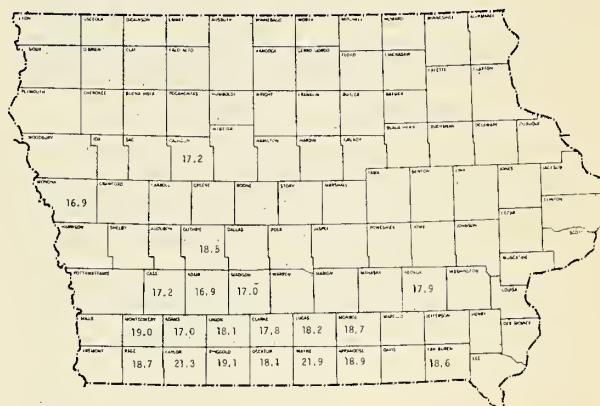


Figure 1. The 20 counties in Iowa with the highest percentage of persons 65 and over.

As in the national distributions, the 20 counties with the highest *numbers* of elderly tend to be essentially urban, as shown in Figure 2. The 6 shaded counties alone account for about one-fourth of the 65-plus population in Iowa, while the 20 counties account for almost half of the elderly population.

(Please turn to page 478)

The author is a professor and associate dean in the College of Medicine at the University of Iowa. He is widely known for his work in the field of gerontology.

URBAN/RURAL DISTINCTION

This sharp distinction between number and percentage distributions, which focuses attention on urban and rural areas, is termed "the urban-rural dilemma" — the disparity between needs and resources.

Iowa's urban areas (the counties which include such metropolitan centers as Des Moines, Cedar Rapids, Waterloo, Sioux City, Council Bluffs, Davenport, and others represented in Figure 2) contain the greatest re-

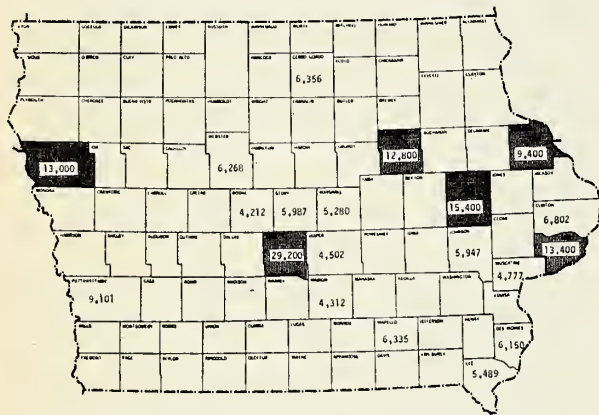


Figure 2. The 20 counties in Iowa with the highest numbers of persons 65 and over.

sources. Their tax bases are greater, which yield larger numbers of personnel to provide services. In the cities the numbers of elderly persons are high, but their proportion to the rest of the population is relatively low.

It is in the rural areas that the largest percentages of elderly live, but their numbers are relatively low. In these counties the tax base is low and resources tend to be sparse, there are few or no transportation systems, and fewer supporting services. Because resources are low or lacking, it is difficult to establish service programs.

Table I lists the rural and urban counties showing the percentages and numbers of persons 65 years of age and older. Some of the demographic characteristics of these two types of counties are summarized in Table II. The differences are dramatic. For example, there are over 4 times as many elderly persons in the 20 urban counties as in the rural counties, but the latter contain a significantly higher proportion of elderly persons. Population projections are not encouraging, since it is expected that total population in the rural areas will continue

a long period of decline by dropping another 12%, while urban areas are expected to increase in population.

Table III shows obvious shortages in almost every kind of health care personnel in the rural counties. In two cases — OTs and OTAs — they are nonexistent.

Long-term care beds per 1,000 population 65-plus are shown in Table IV. They are extremely low in rural areas in the instances of

TABLE I
TWENTY COUNTIES WITH HIGHEST PERCENTAGE OF ELDERLY
CONTRASTED WITH TWENTY COUNTIES WITH THE HIGHEST
NUMBER OF ELDERLY

Counties with highest percentage of elderly		
County	% 65+	No. 65+
Wayne	21.9	1,789
Taylor	21.3	1,717
Ringgold	19.1	1,192
Montgomery	19.0	2,461
Appanoose	18.9	2,892
Monroe	18.7	1,750
Page	18.7	3,512
Von Buren	18.6	1,590
Guthrie	18.5	2,283
Lucas	18.2	1,846
Decatur	18.1	1,751
Union	18.1	2,407
Keokuk	17.9	2,341
Clarke	17.8	1,453
Colhoun	17.2	2,340
Cass	17.2	3,073
Adams	17.0	1,044
Madison	17.0	2,145
Adair	16.9	1,630
Monona	16.9	2,016
Counties with highest number of elderly		
County	% 65+	No. 65+
Polk	9.6	29,200
Linn	9.2	15,400
Scott	8.4	13,400
Woodbury	13.0	13,000
Black Hawk	9.2	12,800
Dubuque	10.2	9,720
Pottawattomie	10.5	9,101
Clinton	11.6	6,802
Cerro Gorda	13.2	6,356
Wapello	15.6	6,335
Webster	13.4	6,268
Des Moines	13.5	6,150
Story	8.2	5,967
Johnson	7.3	5,947
Lee	12.8	5,489
Marshall	12.5	5,280
Muscotine	12.1	4,777
Jasper	12.4	4,502
Marian	14.9	4,312
Boone	16.2	4,212

TABLE II

COMPARISONS OF SOME DEMOGRAPHIC CHARACTERISTICS OF COUNTIES WITH HIGH PERCENTAGES AND HIGH NUMBERS OF ELDERLY

Variables	20 High Percentage Counties		State Total N	20 High Number Counties	
	N	%		N	%
Population 65 +	41,232	10.9	379,000	175,018	46.2
Percentage 65 +		18.1	13.0		12.2
Projected total population changes projected 1970-80		- 12.0	+ 2.4		+ 7.1

residential care and skilled care facilities, in contrast to urban areas. Only intermediate care facilities show an excess in beds in rural counties over urban counties.

Last year The University of Iowa Committee on Aging prepared a report to the General Assembly on demographic aspects of aging in Iowa. Some of the points made there are summarized in the following:

GROWTH IN NUMBERS

During the years between 1900 and 1980 the Iowa population grew by a little less than one-third, from 2.2 million in 1900 to 2.9 million in 1980. In this same period the older part of the Iowa population grew over twofold, from 111,000 to 381,000. The older portion of our population continues to grow faster than the under-65 portion. Between 1900 and 1980, the number of older Iowans increased by 243%, compared to a 17% increase in the under-65 population. As in the rest of the nation, the 75-plus portion of the Iowa population is growing faster than any other age group.

TURNOVER

The elderly are neither homogeneous nor static. The net increase in the older age group in Iowa amounts to about 9 persons a day for a total of slightly over 3,400 a year. This increase includes data on net migration and the natural increase of those Iowans who become 65. It is worth noting that these "newcomers" to the older age group are quite different from and have lived through quite a different life history than those already 65-plus, and are worlds apart from the centenarians who were born shortly after the Civil War.

AGE

The report to the General Assembly showed most older Iowans (those 65 and over) were under 75 (57%); about half (47%) were under 73; and slightly less than one-third (31%) were under 70. About 165,000 Iowans are 75 years of age or over, and about 1,300 are 100-plus. The median age of the Iowa population is 30 years.

(Please turn to page 480)

TABLE III

COMPARISONS OF HEALTH CARE PERSONNEL IN COUNTIES WITH HIGH PERCENTAGES AND HIGH NUMBERS OF ELDERLY

Variables	20 High Percentage Counties			State Totals		20 High Number Counties		
	N	N/1,000 65 +	% State Total	N	N/1,000 65 +	N	N/1,000 65 +	% State Total
Primary physicians	112	2.7	8.3	1,343	3.5	787	4.5	58.6
Dentists	69	1.7	5.8	1,190	3.1	769	4.4	64.6
Occupational therapists	0*	0.0	0.0	119.5†	0.4	101‡	0.7	84.5
O.T. assistants	0*	0.0	0.0	39.5†	0.1	29.5‡	0.2	74.7
Public health nurses	41	1.0	12.1	341	0.9	173	1.0	50.9
Physical therapists	10*	0.3	3.6	280†	0.8	221‡	1.5	78.9
Speech pathologists	7*	0.2	2.9	240†	0.7	173‡	1.2	72.1
Audiologists	1*	0.03	1.5	65†	0.2	54‡	0.4	83.1

* Based on data from only 16 of the 20 counties sampled.

† Based on Iowa HSA which is 88 of Iowa's 99 counties.

‡ Based on data from only 17 of the 20 counties.

Sources: Iowa Health Systems Agency, *Long Term Care in Iowa Background Report*, January 1981. Iowa State Department of Health, Division of Licensure, 1978. Iowa State Department of Health, *Monthly Report of Public Health Nursing*, 1980.

TABLE IV
COMPARISONS OF LONG TERM CARE BEDS IN COUNTIES WITH HIGH PERCENTAGES AND HIGH NUMBERS OF ELDERLY

Variables	20 High Percentage Counties			State Totals		20 High Number Counties		
	N	N/1,000 65+	% State Total	N	N/1,000 65+	N	N/1,000 65+	% State Total
Residential Care Beds	598	14.5	6.7	8,918	23.5	4,481	25.6	50.2
Intermediate Care Beds	3,615	87.7	11.8	30,766	81.0	13,790	78.8	44.8
Skilled Core Beds	12	0.3	1.0	1,124	3.0	1,009	5.8	89.8

Source: Iowa State Department of Health, Long Term Care Facilities by County, March 1980.

PERSONAL INCOME

The data show older economic units in the U. S. have half of the income of their younger counterparts. Half of the families headed by an older person had incomes of less than \$10,141, compared to \$19,310 for families with heads under 65. In Iowa, families headed by an older person had median incomes less than \$8,548. The median income of older persons living alone was \$4,303, compared to \$8,530 for those under 65. The median income of single older persons was \$3,628, with men receiving more (\$5,392) than women (\$2,740).

TABLE V
HOSPITAL USE & DISCHARGE RATES PER 10,000 IOWANS
SEPTEMBER 3/30, 1977

Age/Sex Category	State Use Rate	State Discharge Rate
00-14		
Total	251	62
Male	287	69
Female	213	55
15-44		
Total	679	131
Male	506	83
Female	849	178
45-64		
Total	1,176	151
Male	1,186	149
Female	1,166	153
65+		
Total	2,761	284
Male	3,034	318
Female	2,574	261
All Ages		
Total	941	138
Male	856	118
Female	1023	157

(Compiled by Research and Data Management, Iowa Health Systems Agency; data from Patient Information an Hospital Service Area, September 3-30, 1977, Iowa State Department of Health.)

Some 3.2 million, or one-seventh of the elderly in the U. S., had incomes below poverty thresholds (\$3,917 for older couples, and \$3,116 for older individuals). Women and minority aged persons are heavily overrepresented among the elderly poor. To set these data out in bold relief, the theoretic "retired couple budget" prepared by the Bureau of Labor Statistics for a modest but adequate intermediate standard of living came to \$7,846 in 1978. A lower budget came to \$5,514, and a higher one came to \$11,596.

HEALTH CARE

Total Health Costs. The total health care bill in Iowa in 1976 was \$1.67 billion, a dramatic increase over the preceding 10 years. This increase in health care costs results from vast technical changes, very rapid price increases, "aging" of the population, and increased utilization made possible by the provision of increased health care resources — especially through public programs, and through the utilization of expensive inpatient facilities.

Personal Health Care Expenditures. These expenditures (which exclude costs of research, construction and certain public health activities such as contagious disease control) in Iowa rose from \$469 million in 1966 to \$1.5 billion in 1976. Iowa per capita cost for health care in 1976 was \$532. A conservative estimate suggests that health care expenditures of older Iowans amounted to more than \$311.8 million, which is \$834 per capita.

In 1979 Medicaid paid claims of \$200 million to 160,000 Iowans, which amounts to \$1,250 per capita. During the same year, Blue Cross-Blue Shield of Iowa paid out total benefits of \$1.5 billion. In addition, Blue Shield paid for its biggest client — the federal government's Medicare program — \$491.4 million in claims.

While the exact figures are not known, most of these funds go to providing health care for the elderly.

Older Iowans represent slightly over 13% of the state's population, but they account for 20% of the total personal health care expenditures. Of these \$311.8 million, only \$110 million, or about one-third, came from private sources, and \$201 million or two-thirds were paid by public programs.

Utilization of Health Care Resources. Older people are subject to more disability, see physicians 50% more often, and have about twice as many hospital stays that last almost twice as long as younger persons. Still, some 82% of the elderly report no hospitalization during the previous year.

In 1977 in Iowa the average daily census of 65-plus patients in 132 short-stay hospitals was about 3,800, compared to 2,600 in the middle-aged group. Older patients' hospital stays averaged about 10 days, compared to 8 days for middle-aged patients.

These data and those in Table V demonstrate that the 65 and older population use hospital beds at a rate higher than any other age group, with greater utilization by males than by females. Adequate discharge planning might reduce utilization of expensive hospital beds.

In 1980 there were 30,673 intermediate-care beds, 8,873 residential-care beds and 1,075 skilled-care beds. A shortage of skilled nursing-care beds exists in Iowa with these facilities in only 16 of the 99 counties. No doubt the explanation lies in the costs for additional required professional staff as well as inadequate reimbursement, and the strict interpretation used in qualifying patients for skilled care. If more skilled beds were available, it would permit earlier discharge of many patients from the more expensive acute-care hospital beds.

Of the 27,839 Iowans estimated to be in intermediate-care facilities at any one time in 1979, 92% were in the 65-plus age group. Of these, 87% were aged 75-plus. Women outnumbered men by 2.5 to one.

There were 6,769 persons at any one time living in residential care facilities, 58% of whom were 65-plus. Of these, 70% were 75-plus. Again, women outnumbered men by a sizeable proportion (1.7 to one).

The incidence of admission to skilled nursing facilities per year over the past 5 years has been consistently 4,000. "Incidence of admis-

sion" to skilled-care facilities is used in place of "number at any one time" because there is a shorter length of stay (thus a more rapid turnover) in skilled facilities.

Death Rates. Over the past 10 years the annual death rate for Iowans dropped 6.7%, from 6.0 to 5.6 per 100. Within the older population there were these variations: the rate for persons 65-74 dropped 15% from 3.3 to 2.8 per 100; the rate for those 75-84 dropped 10% from 7.7 to 6.9 per 100; and the rate for those 85 and older dropped 21% from 26.0 to 20.5 per 100.

Causes of Death. The death rates of older Iowans from heart disease declined slightly to about 2.5 per 100 in 1978, and the death rate for stroke was 0.7 per 100. The death rate for cancer was about 1.0 per 100. These three causes of death among the elderly accounted for three-fourths of the deaths.

LIFE EXPECTANCY

Life expectancy for Iowans increased from 71.9 years in 1961 to 73.3 in 1978. Life expectancy in Iowa in 1978 was greater than the U. S.

(Please turn to page 482)

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average for all ages specified until age 85.

As is true throughout the nation, the average life span for females in Iowa was 7.7 years longer than the 71.2 for males. In Iowa at age 65, the life expectancy of women exceeded the remaining years for men by 4.4 years.

The increase in life expectancy during this century results from the wiping out of most of the killers of infants and the young. Much smaller improvement has occurred in the upper ages when chronic conditions and diseases become the major killers. Many more people now reach 65 (about 76% versus 40% in 1900) but, once there, they live only 4.1 years longer than did their ancestors who reached that age in the past. Should recent decreases in death rates continue among older people, especially from cardiovascular conditions, life expectancy in the later years may increase further.

The following statement from the 1980-85 *State Health Plan for Iowa* is apropos: "More

Iowans should be living to at least age 75. In 1970, in Iowa and in the United States, for persons at birth and at one year of age, the average life expectancy is about 73 years. But, since in some European countries life expectancy is well over 75 years at birth, in Iowa, 75 years is also an attainable life expectancy. . . . About half of the premature deaths in Iowa are caused by lifestyle factors. Clearly, changing lifestyles would have the greatest impact on preventing premature deaths. Lifestyle changes in obese, hypertensive, unemployed, low-skilled workers will not come about without accompanying changes in their social and economic environments. Declines in the rates of premature mortality in Iowans will come about as a result of understanding the complex interplay of lifestyle, environmental, biological, and health care system factors, and of implementing a policy of preventive programs which reflects this complex interplay."

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Acute Referral Hospital Care In Geriatric Internal Medicine

IAN M. SMITH, M.D.,

Iowa City, Iowa

INCREASINGLY LARGE NUMBERS of elderly persons are receiving acute hospital care. While admissions at all ages have increased 9%, those patients 65 and over entering hospitals are up 37%.²

This provokes some hard questions. *Can hospital medical staffs meet the needs of acutely ill aged patients? Is sufficient help available to give these patients the greatest possible degree of comfort and independence? Do hospital admissions for the elderly promote dependence, or do they more often stimulate a return to independent living?*

There are more elderly persons in acute care beds at all times than there are in long term care beds (such as in nursing homes), according to British studies. There are no U.S. figures to parallel these British statistics; however, there are 1.3 million acute care hospital beds in this country with an average stay of 12 days per patient 65 and over; there are 1.4 million long term care beds with an average stay of 597 days.^{1, 3}

This question emerges: How often will \$4,200 or more (average cost for U. of I. patients) spent for acute care hospitalization of 13 days prevent a \$17,000 annual nursing home cost which often lasts 10 to 15 years? Another offshoot question: Should we press for ex-

Care of the elderly in Iowa is of key importance. The percentage of population above 65 is among the nation's highest. Described here are findings and activities emanating from the University of Iowa which demonstrate the increased interest in serving health care needs of older Iowans.

panded home care to decrease the need for nursing home accommodations after acute care hospitalization?

The Internal Medicine Geriatric Program was established at the University of Iowa nearly two years ago. It has been seeking answers to these questions. Our studies have compared two patient groups, those between the ages of 30 and 49 and those 70 and over. We have examined autopsy records. We have reviewed in-hospital and outpatient records for diagnosis, treatment, complications and prognosis. We have evaluated the use of high technology in medicine and surgery. We have traced the significance and characteristics of pneumonia, septicemia and systemic lupus erythematosus, etc. This paper offers preliminary indications from these studies.

STATISTICAL BACKGROUND

The University of Iowa Hospitals has 1,100 beds and is staffed by 895 physicians, 941 nurses, 724 other professionals and 2,926 additional hospital staff. There are 40,204 admissions and 318,000 outpatient visits annually. The Department of Internal Medicine admits annually an average of 1,116 patients between ages 30 and 49; it admits an average of 1,178 patients 70 and over. The Department serves more than 15,000 general medical outpatients

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TABLE I
PRIMARY & SECONDARY AUTOPSY CAUSES OF DEATH

361 Deaths at Age 30-49			443 Deaths of Age 70 & Over		
	#	%		#	%
All cancers	121	34	All cancers	133	30
Septicemia	60	17	Myocardial infarction	66	15
Cirrhosis	37	10	Septicemia	66	15
Pneumonia	35	10	Pneumonia	57	13
Leukemia	30	8	Postoperative complications	56	13
Postoperative complications	31	9	Leukemia	36	8
Subarachnoid hemorrhage	27	7	Pulmonary emboli	33	7
Myocardial infarction	26	7	Cardiac failure	27	6
Cerebrovascular accidents	23	6			
Gastrointestinal hemorrhage	20	6			

All causes comprising 3% or more of deaths are included.

each year, with some 10,000 of these being new patients.

STANDARD PROCEDURES

On admission to the internal medicine service, all patients receive a complete blood count, a urinalysis, 18 automated biochemical tests, PT, PTT, a chest x-ray and an EKG. Findings from these records have been analyzed in our studies.

For purposes of this research high technology care has been defined to include computerized axial tomography, isotope-ventriculogram, Holter monitoring, treadmill examination with cardiac imaging (but not treadmill examination alone), direct needle aspiration of the lung, electronystagmograms, arteriograms, endoscopic retrograde cholangiographic pancreatography and colonoscopy.

Treatment procedures categorized as high technology care include pacemaker placement, cardiac valvular operations, coronary artery bypass, cerebral vessel bypasses, abdominal aortic aneurysm replacement, hip and knee replacements, nerve stimulator pain control, hemodialysis and peritoneal dialysis. Special units rendering intensive care, such as MICU, SICU and CCU, are included in the survey of high technology use in the care of the elderly. Referral activity has also been analyzed as to amount and type.

The study objectives have been: (1) to examine the causes of death among the elderly in a tertiary care setting; (2) to assess disease information on patients admitted to internal medicine service; (3) to evaluate what preventive measures might have prevented admission, and (4) to determine what care (of specified diseases) is likely to produce

(Please turn to page 485)

TABLE II
PREVALENCE OF DISEASES IN INPATIENT INTERNAL MEDICINE PATIENTS

Prevalence	Age 30-49 (%)	Age 70 - over (%)
10-28%	Hypertension (17) Diabetes (14) Alcohol Abuse (13) Urinary Tract Infection (10)	Hypertension (28) Cardiac Failure (18) Angina (12) Urinary Tract Infection (12) Diabetes (11) Chr Obstructive Pulm Dis (11) Pneumonia (11) Coron Art Dis/OHD (11) Chr Renal Failure (10)
5-9%	Asthma (9) Chr Renal Failure (8) Angina (7) Cardiac Failure (6) Duodenal Ulcer (6) Pancreatitis (6) Cirrhosis (6) Epilepsy (6)	Myxedema (8) Pacemaker Use (6) Aortic Stenosis (6) Up.GI Bleed (6) Dementia (6) Iron Defic Anemia (6) Septicemia (5) Asthma (5) Lymphoma (5) Previous M.I. (5) Lung Cancer (5) Supraventricular Tachy (5) TIA (5)

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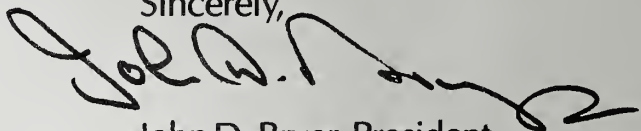
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In patients with active peptic ulcer and active rheumatoid arthritis, nonulcerogenic drugs, such as gold, should be attempted. If Rufen must be given, the patient should be under close supervision for signs of ulcer perforation or gastrointestinal bleeding.

PRECAUTIONS: Blurred and/or diminished vision, scotomata, and/or changes in color vision have been reported. If developed, discontinue Rufen and administer an ophthalmologic examination.

Fluid retention and edema have been associated with Rufen; caution should be used in patients with a history of cardiac decompensation.

Rufen can inhibit platelet aggregation and prolong bleeding time. Use with caution in patients with intrinsic coagulation defects and those taking anticoagulants.

Patients should report signs or symptoms of gastrointestinal ulceration or bleeding, blurred vision or other eye symptoms, skin rash, weight gain or edema.

To avoid exacerbation of disease or adrenal insufficiency, patients on prolonged corticosteroid therapy, this therapy should be tapered slowly when adding Rufen.

DRUG INTERACTION: Coumarin-type anticoagulants. The physician should be cautious when administering Rufen to patients on anticoagulants.

Aspirin. Concomitant use may decrease Rufen blood levels.

PREGNANCY AND NURSING MOTHERS: Rufen should not be taken during pregnancy nor by nursing mothers.

ADVERSE REACTIONS

Incidence greater than 1%

Gastrointestinal: The most frequent adverse reaction is gastrointestinal (4% to 16%). Includes nausea*, epigastric pain*, heartburn*, diarrhea, abdominal distress, nausea and vomiting, indigestion, constipation, abdominal cramps or pain, fullness of GI tract (bloating and flatulence). **Central Nervous System:** dizziness*, headache, nervousness. **Dermatologic:** rash* (including maculopapular type), pruritus. **Special Senses:** tinnitus. **Metabolic:** decreased appetite, edema, fluid retention. Fluid retention generally responds promptly to drug discontinuation (see PRECAUTIONS).

*Incidence 3% to 9%.

Incidence less than 1 in 100

Gastrointestinal: gastric or duodenal ulcer with bleeding and/or perforation, hemorrhage, melena. **Central Nervous System:** depression, insomnia. **Dermatologic:** vesiculobullous eruptions, urticaria, erythema multiforme. **Special Senses:** amblyopia (see PRECAUTIONS). **Hematologic:** leukopenia, decreased hemoglobin and hematocrit. **Cardiovascular:** congestive heart failure in patients with marginal cardiac function, elevated blood pressure.

Causal relationship unknown

Gastrointestinal: Hepatitis, jaundice, abnormal liver function. **Central Nervous System:** paresthesias, hallucinations, dream abnormalities. **Dermatologic:** alopecia, Stevens-Johnson syndrome. **Special Senses:** Conjunctivitis, diplopia, optic neuritis. **Hematologic:** hemolytic anemia, thrombocytopenia, granulocytopenia bleeding episodes. **Allergic:** fever, serum sickness, lupus erythematosus syndrome. **Endocrine:** gynecomastia, hypoglycemia. **Cardiovascular:** arrhythmias (Sinus tachycardia, bradycardia, and palpitations). **Renal:** decreased creatinine clearance, polyuria, azotemia.

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an independence and a reasonable return to quality of living. The group of patients between the ages of 30 and 49 was compared to help ascertain the significance of disease acquired earlier in life.

AUTOPSY DATA

In the studies undertaken, 3,035 autopsies at the University have been surveyed. Of these, 11.1% were in the 30-49 group; 14.6% were in the 70 and over group.

The primary and secondary causes of death were compared in the autopsy reports to see what differences existed in the two age groups.⁶ Of the 3,035 autopsy reports between 1973-79, 361 were in the 30-49 age group and 443 were in the 70 and over group. Sixty percent of the autopsies came from the medicine services, compared with 40% from the surgical services, in both age groups. The 70 and over patients averaged 5 to 6 major diagnoses each, compared with 2 to 3 in the younger group.

The 3 most common causes of death in the young are septicemia, cirrhosis and pneumonia. In the older group, myocardial infarction, septicemia and pneumonia are most common (Table I). If all cancers are grouped together, they become the most prevalent cause of death in both age groups. Primary and secondary causes of death were combined in the study because of the frequent inability to differentiate between them in the autopsy reports.

More elderly men died in the hospital than elderly women. This corresponds to a national survival rate of 136 women for every 100 men at age 60, and 217 women for every 100 men over age 80. The reason for the lesser admission rate for elderly women is an interesting question.

SPECIAL PATIENT SAMPLE

A sample of 687 patients seen by the author in 9 separate monthly rotations between 1978 and 1981 was analyzed.⁷ Of these, 125 (18.3%) were in the 30-49 group, while 134 (19.5%) were age 70 or over. Hypertension, diabetes and urinary tract infection were common in both groups. Diagnoses more distinctive in the younger group were alcohol abuse, cirrhosis, pancreatitis, duodenal ulcer and epilepsy. More common among the elderly were cardiac failure, chronic obstructive pulmonary disease, pneumonia, coronary artery disease, myxedema, pacemaker use and dementia.

Some bias is present in these figures — for example, strokes and dementia frequently are preferentially admitted to the neurology service (Table II)

The most common referrals required for the young were gastroenterology (17%), cardiology (16%); psychiatry (11%), and surgery (10%). By contrast, the most common referrals for the elderly were cardiology (19%); hematology-oncology (18%); gastroenterology (16%), and thoracic-cardiovascular surgery (13%). The number of consultations needed per patient did not differ in the two groups; it averaged 0.8 per patient. Fourteen percent of the young and 8% of the old received no consultation.

The elderly averaged 12 days in the hospital; the range was from 2 to 70 days. The younger group averaged 10.9 days with the range from 1 to 40 days.

High technology diagnostic procedures (as specified earlier) were used in 23% of the young and 28% of the old. High technology treatment was used in 20% of the young and 33% of the elderly. Intensive care units were used for 6% of the younger patients and 9% of the elderly. Patients admitted directly to and discharged directly from intensive care units were not included in this analysis.

Hospital complications became involved with 5% of the young and 10% of the elderly. Most common among the elderly was acute renal dye failure (2%). Drug reactions were not included. Studies are in progress at the University to identify causes of the increased risk of nosocomial infections in the elderly.

FORM OF TREATMENT

Medical treatment in elderly women most frequently included digitalis, prednisone, gentamicin, insulin, aminophyllin and ferrous sulfate. In elderly men digitalis, ampicillin, aminophyllin, lasix, prednisone, gentamicin and the thiazides were used most often, in that order. Thirty-five other medications were used less often. Among young women prednisone, hydrochlorothiazide, insulin and aminophyllin were used most frequently, but 66 other medications were also recorded. In young men insulin, cimetidine, thiazides and antacids were used most often with 35 other medications as well.

Surgical treatment varied in the age groups: breast biopsy and abdominal surgery in elderly women; urologic surgery, cholecystectomy

TABLE III
SURGERY IN PATIENTS 70 & OVER

Low case fatality rates		High case fatality rates	
Transurethral prostatectomy	4%	Aortic graft	19%
Below the knee amputation	3%	Partial colectomy	15%
Cholecystectomy	3%	Above the knee amputation	12%
Cataract removal	<1%	Exploration of inoperable thoracic or abdominal cancer	12%

and vascular surgery in elderly men. In young women ear, nose and throat surgery, abdominal surgery and biopsies were common, and in young men pancreatitis-related operations were the most common. A detailed study of mortality according to age for various surgical procedures in this hospital has been published recently.⁹ It is extremely useful in advising elderly patients and their families (Table III).

DISCUSSION

Obviously, much of the country's acute geriatric care occurs in U.S. hospitals. The admission rate for patients age 65 and over has increased about 48% in 10 years. Studies are needed to follow the elderly while they are in the hospital and after discharge. A limited amount of information is reported from this study. More comparative research is needed.

The elderly must not be separated from the medical mainstream. They must continue to receive as detailed and expert care as the young. This cannot always be accomplished in a geriatric ward or geriatric hospital where necessary specialized professional and technical help is more limited in availability. Hospital care can, however, lead to complications and care must be taken to minimize these.

In January, 1980 an Internal Medicine Geriatrics Program was established at the University of Iowa to deal with these matters. A similar program was initiated by the Department of Family Practice. The two programs are coordinated for patient care, teaching and research.

Patient care starts with an assessment clinic where elderly patients are studied intensively as to their medical, social and nursing needs. A surveillance service affords visitation for all patients on the medical service age 70 and over. This has recently been extended to include surgery, urology and psychiatry. A consulta-

tion service is offered to cover special problems of the elderly. We are studying coordinated discharge planning. Follow-up home visits are being made to reduce the need for re-admission or institutionalization.

Sophomore medical students are receiving expanded instruction in geriatrics in the Introduction to Clinical Medicine course. Two electives on geriatrics have been introduced; one in internal medicine and one in family practice. A residency program is active in family practice and a fellowship program has been organized in internal medicine.

Joint teaching occurs in weekly geriatric seminars where speakers from various departments discuss osteoporosis, dementia, cardiac pacemakers and other medical problems of the elderly. In a second teaching experience, geriatric grand rounds, there is a discussion of patients seen on surveillance rounds.

Research on individual diseases of the old, such as systemic lupus erythematosus and infections in elderly diabetics, is in progress. Other departments within the hospital and University are conducting research on stroke, dementia, osteoporosis and other subjects; this amounts to \$6-7 million in work yearly which bears on aging.

CONCLUSIONS

We have reported superficially the findings of studies at the University of Iowa. Myocardial infarction, septicemia, pneumonia and postoperative complications are the most common causes of death among the elderly.

Accurate diagnosis, through available means, is important so the elderly may maintain health and the greatest possible degree of comfort and independence. Total use of hospital and community medical and social services is important.

The elderly must be kept in the mainstream

of medical care. Ongoing instruction and teamwork are needed to make the most effective use of existing medical services in providing for the care of the elderly.

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PRIMARY HEALTH NEEDS OF THE ELDERLY IOWAN

(Continued from page 473)

Iowa. The emphasis is appropriately on local or community-based living and support.

Where and when needed, tertiary-level services are available. For example, there are a variety of specialized programs to meet high level needs of the aging patient at the University of Iowa Hospitals and Clinics. The clinical

departments provide a full range of services to maintain a good health status.

The matter of costs has not been addressed particularly. There is obvious concern over increasing health care costs for the elderly in face of fixed or declining incomes. The limitations and complexities of Medicare do not ease this problem. This topic must have ongoing and serious attention.

Health education and preventive care — covering nutrition, immunizations, physical examinations, etc. — can impact favorably on the quality of life for elderly Iowans. The future holds much promise for further progress.

AUXILIARY HOLIDAY CARD

A new holiday project is being undertaken this fall by the Iowa Medical Society Auxiliary in the belief it can become a successful annual tradition. Involved is a holiday greeting card designed by an Iowa physician. The holiday card will be used by several counties as a Sharing Card project. Those contributing to the project will have the opportunity to designate their donation for the medical school of their choice. Proceeds from additional card sales will be given to the U. of I. College of Medicine. The cards are appropriate for use at any time.

The 1981 holiday card shows a watercolor by Iowa physician/artist Webster B. Gelman, M.D., an orthopedic surgeon who has been in private practice in Iowa City since 1950. The picture is a graphic testimony to the world of

art and depicts colorfully the tools of the artist. The message of the card is appropriate to the watercolor: *Those who now imagine will later create. May your home be filled with the magic of imagination and love.*

At least three county auxiliaries (Jackson, Polk and Pottawattamie-Mills) and one member-at-large district (10) are expected to sponsor the project by inviting members of the county medical society to make specific donations to the American Medical Association Education and Research Foundation (AMAEF), in return for which they will have their names acknowledged in a mailing of the card to all of the local physicians.

For further information about this project (or to order cards) please contact either Sandy Nichols at IMS headquarters (515/223-1401 or 800/422-3070) or Randee Fieselmann (515/987-4868). The cards are also being sold by Auxiliary leaders around the state.

Helping the Family Of the Elderly Patient

JOYCE BOWDISH, B.S.N., M.S.N.

Cedar Rapids, Iowa

HEALTH PROFESSIONALS are becoming increasingly conscious of the importance of considering the family as a functional unit in the delivery of care. Generally, this means treating the nuclear family — parents and offspring living in the same household. Obviously, there may be no such nuclear family where death of a spouse has occurred or there has been movement of grown children into their own homes.

Family interactions are obviously important to the elderly. Shanas reports 4 of 5 old people in the United States have living children. Of those with children, 2 of 3 either live with a child or are no more than 10 minutes away from one of them.¹ In a national study, half of all the old people who had children, but did not live with them, saw their children either on the day they were interviewed or on the day previous. Furthermore, where there are no children, other relatives, such as siblings, cousins, nieces or nephews, often replace children in helping elderly family members.² Such findings demonstrate the involvement of families in deciding the future of their elderly members.

The numbers of elderly patients are increasing as people live longer. And as life expectancy increases, there is the inevitable onset of

The concerns of the family for its elderly members need to have conscientious support from Iowa health care professionals. Deciding what is best for "mom" and/or "dad" takes patience and a willingness to examine the options available. The physician is often called on to supply first line guidance on what the alternatives may be.

one or more chronic conditions. Health professionals may have limited interaction with the family of an elderly patient until a serious health problem threatens his/her independence. When this happens, the family often seeks help, and it is frequently the physician or other health professional to whom they turn for advice. Thus, the potential concerns of families need to be known and ways found to provide effective support. The physician must evaluate conditions and interact with the family to produce the best possible outcome for the elderly patient.

Concern about an elderly parent often arises during the middle years. This can be a time of stress for the adult offspring who has obligations to his or her own children, spouse, job and community, as well as to elderly parents. The adult child may have difficulty finding adequate time and energy to assist his/her parents.

Part of this difficulty is enhanced by the changing roles of women in today's society. Traditionally, adult women have cared for the elderly. Now, however, more women are working outside the home and are not as available to help ailing parents.³ In addition, it may be difficult for the middle aged child to face the aging of his parent. It is a reminder the parent

The author is a geriatric nurse practitioner at the Public Health Nursing Association of Linn County in Cedar Rapids, Iowa.

will not be around forever and points to the personal aging of the adult child.

SCAPEGOAT SYNDROME

If stress occurs among the adult children, the elderly person may become a convenient scapegoat for everything that is wrong in the family. Sudden dependency of an elderly parent or relative can rekindle a long-standing negative relationship or an unresolved conflict which has been dormant for years. This will definitely affect the response of the family to the elderly member.

Feelings of anger, guilt, panic, frustration and helplessness may develop no matter how much love and concern there is for the aging member. Anger can develop due to demands on family time and resources and a lack of apparent appreciation by the elderly family member. Anger can also emerge within the family unit, i.e., between spouses, siblings, as disagreements occur on how to best help the elder. Guilt can result from unrealistic expectation of self and others, manipulative behavior by the older person or worry about what others, such as friends and neighbors, believe should be done.

The family may need help identifying and dealing with these feelings. If family members are unable to respond positively to these feelings, their ability to help the older member is jeopardized. The health professional can help the family by offering reassurance that these feelings are normal, but assuring they do need to be dealt with in a positive manner. There should be encouragement to keep family communication channels open. Ideally, the family should have done some planning before any crisis occurs. This will help keep emotions in check. Often family members can develop a healthy perspective when the possible causes of their feelings are explained.

Sudden dependency caused by a dramatic health change can be difficult for a family. When this occurs the highly-valued element of independence must be traded for more *interdependence*. The family often worries about the safety of an elderly parent, but feels trapped as advice and assistance are rejected by the elderly member. As this happens the family may need help to decide when and how to assist.

If the family tries to take over, the older person may become resentful and hide his problems for fear that if he admits a need he

will lose all independence. Or he may simply give up and accept no further responsibility for his own care. Families should be guided to help the elderly individual only if absolutely essential and then in a manner that attempts to include him in all decisions. Independence should be preserved as long as feasible.⁴ Often families decide about elderly members out of a need to feel less anxious or guilty, rather than a concern for the best interest of the older persons.

A major family crisis may develop if institutionalization of an elderly parent seems necessary. This can be one of the most unhappy times in the life of any human being or family.⁵ The family may need help to examine all available alternatives. If nursing home placement seems essential, the family may need support to cope with fears and concerns. Hasty decisions should be discouraged and much thought should be given to choosing the right facility.

The health professional can help in several ways to improve the potential of the family to provide assistance to the elderly patient. A thorough knowledge of the family situation is crucial before sound advice can be given. What is the perception of the family as to the problems of the elderly patient? Does this perception correspond with that of the health provider and the patient himself? A brief family history is essential to determine the composition and to identify unresolved conflicts, as well as human and financial resources.

It is generally not helpful to engage in a power struggle with the family or elderly patient by giving unconditional support to either. *Any solutions involving elders and their families that are unacceptable to any member of the family are generally nonsolutions.*⁶ The role of the health professional is to facilitate the decision-making process by exploring options and consequences. The family must come to its own decision.

The physician will often have to deal with the family fears and different levels of understanding. A thorough explanation of medical problems and treatment plans is important. Information on the aging process needs to be shared. The family needs to be encouraged to talk about its fears so questions and concerns can be addressed. Specific guidance on the care of a bed patient may be necessary. The

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QUESTIONS - ANSWERS

LARRY L. BREEDING
Des Moines, Iowa

OLDER IOWANS AND THEIR ACCOMMODATIONS

Living and non-acute care accommodations for older Iowans are assessed in the following comments by Larry L. Breeding. Mr. Breeding praises the Iowa Foundation for Medical Care for fostering good relations between facility administrators and physicians. Mr. Breeding is executive vice president of the Iowa Health Care Association, a non-profit organization of proprietary and non-proprietary long term health care facilities.

Do you have any idea as to what number of senior citizens (and what percentage of that population) reside in Iowa nursing homes?

The population in Iowa's long term care facilities is 40,000, of which 35,000 would be classified as senior citizens. This represents 6% of the over-65 population which very closely approximates the national average.

Could you differentiate briefly between the types of homes in Iowa which serve mainly the older citizens?

The three licensed levels of long term care

facilities in Iowa are Skilled Nursing Facilities (SNF), Intermediate Care Facilities (ICF), and Residential Care Facilities (RCF). SNF's provide restorative and rehabilitative services which return an individual to his/her maximum level of living capability. The ICF provides maintenance level services designed to maintain the individual at his/her maximum level of functioning. The RCF provides no nursing services, but does provide those non-medical services or assistance in daily living which individuals need but which cannot be provided in their home on a routine basis.

What are the one, two or three most crucial problems facing those who seek to provide living and non-acute health care assistance to senior Iowans?

The singular, most critical problem facing long term care providers is inadequate Medicare and Medicaid funding. This inadequacy goes beyond not covering total costs, it diminishes innovativeness in the delivery of services. There was certainly every intent to take care of Iowa's infirmed elderly, but Medicare and Medicaid grossly underestimated the number and amount of medical services needed by the elderly, as well as the factor of longevity.

Another crucial problem is the ability to attract and retain qualified professional help, particularly nurses. It is not that long term care facilities are not competitive with other health care providers, it is that the facilities must also compete with a myriad of outside employment opportunities available to nurses in non-nursing settings, many of which were unavailable years ago. This is particularly acute in rural Iowa where the preponderance of facilities are located.

The ever changing role of government and its constantly revised requirements are a continual concern of providers. New laws, rules and regulations create ongoing administrative turmoil as facilities attempt to stay in compliance. While we have made some strides in consolidating and lessening regulatory paperwork requirements, there seems to be a never ending stream of new ideas and concepts which require documentation and constant change in operating procedures.

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QUESTIONS/ANSWERS

(Continued from page 491)

Have we gone forward or fallen back in this sector in the past 5 to 10 years?

Long term care has moved forward in the last 5-10 years at a pace probably unexcelled in any other health care sector. While it is fashionable to make disparaging comments about Medicare and Medicaid, the fact remains that these programs with their tremendous infusion of money, have provided infinitely better and more accessible medical care to the elderly citizens of this country. The difference between the modern long term care facility and the services delivered by its counterpart of 15 years ago defy description. Iowa has taken a leading role nationwide in improving long term care services to the elderly and even though it has been costly, I believe it is recog-

nized as a very proper, necessary and appropriate expenditure of health care dollars.

Is there generally a good spirit of cooperation between your administrators and the medical profession as they together serve our elderly population?

I believe the relationship between Iowa physicians and facility administrators is very good. Probably the biggest contributing factor to that has been the Iowa Foundation for Medical Care. Its work in helping physicians and administrators understand the role each has to play in the delivery system has been very valuable. We recognize the frustrations physicians have with the paperwork and regulations with which facilities must comply and this undoubtedly is the biggest continuing irritant. I believe that with continued cooperation and realization that the over-65 group is the largest growing segment of the Iowa population, relationships in the future between physicians and administrators will be even better.

HELPING THE FAMILY OF THE ELDERLY PATIENT

(Continued from page 489)

physician probably will not be responsible for training of this type, but should know where the family can get such information and help.

The multiple needs of the elderly patient may be overwhelming to the family. The health professional may help the family think realistically about what it can offer in help and assistance.⁷ Realistic expectations must be based on an understanding of the health, work situation, income and emotional stability of the various family members. The number of family members available to help should be known.

There are limits to what a family can do without assistance. And, fortunately, there are community resources to help. Included here are home nursing care agencies. This type of agency can arrange to train the family in basic nursing care procedures and provide intermittent health supervision of the elderly patient. Other community agencies may assist with housekeeping tasks, shopping, home meal delivery, etc. Adult day health care centers are

beneficial where available.

Physicians need to know the programs that serve the elderly in their communities and should help the family to locate them. Where a community information and referral center exists, it can help the physician and the family locate appropriate services.

Health professionals who work with elderly patients will necessarily become involved with family units. To maximize the care potential for both the healthy and impaired elderly person, the physician needs to develop skills in evaluating and helping the family network. The goal is for the family to furnish the best possible level of care to its elderly members with a minimal amount of stress.

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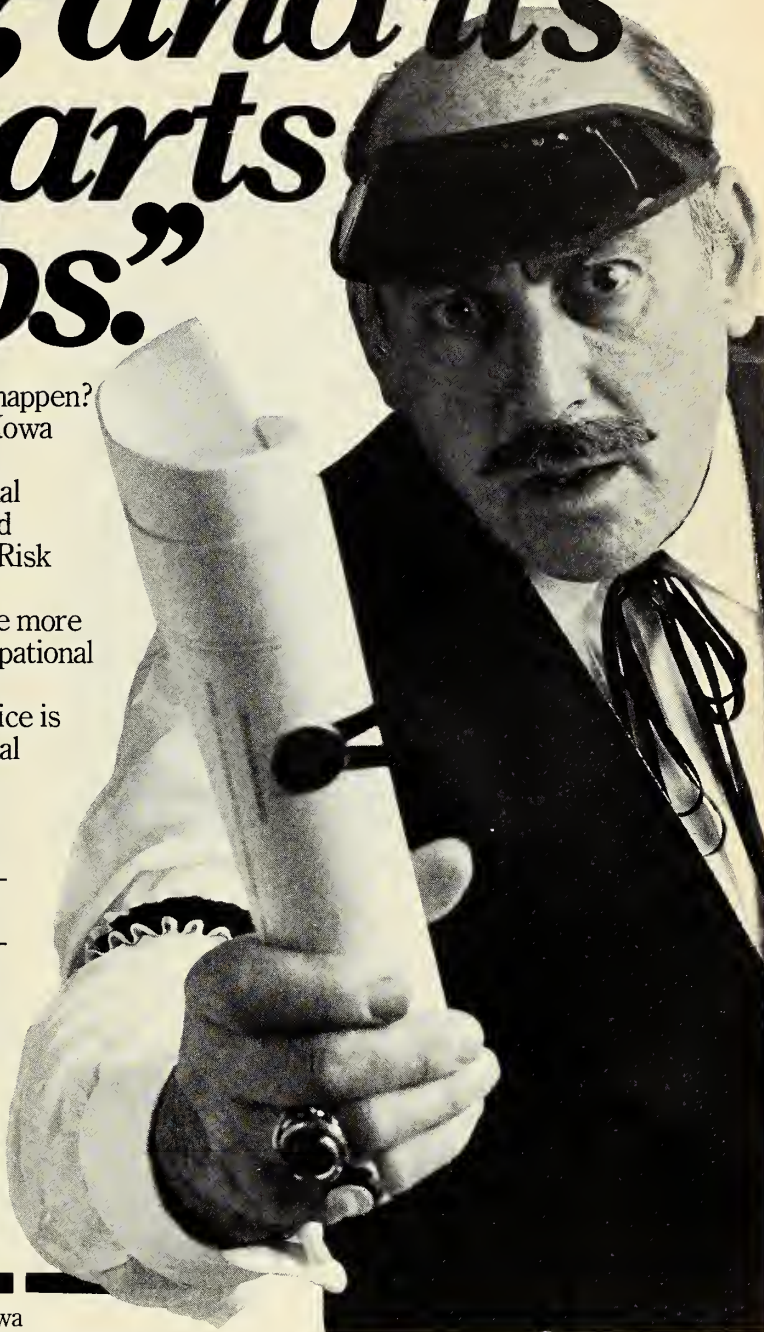
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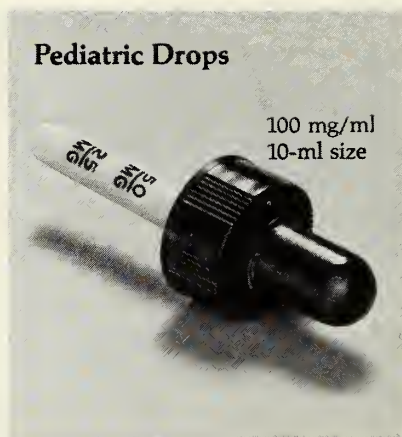
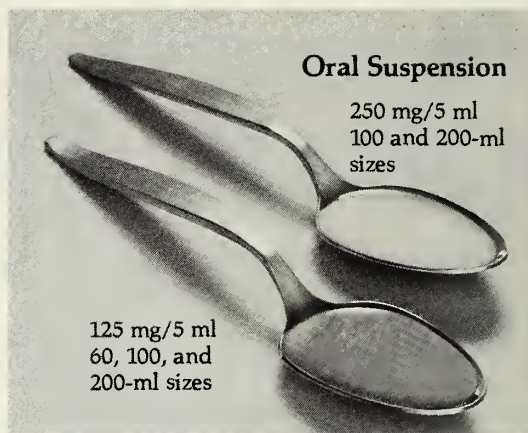
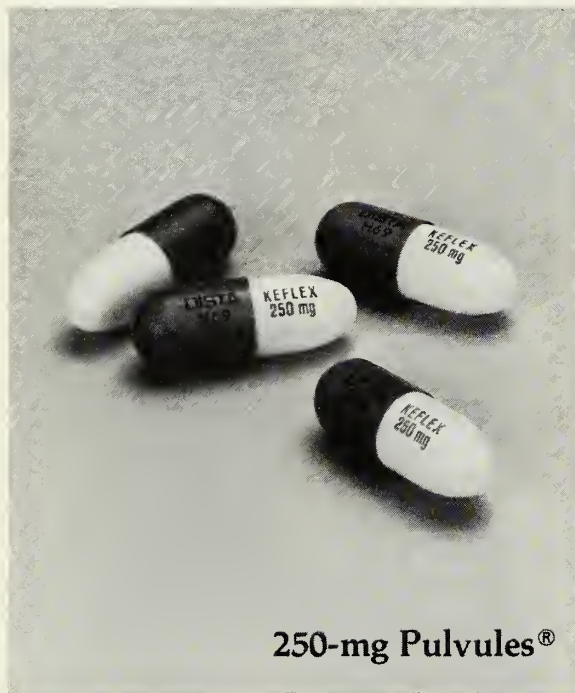
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COMMENTING EDITORIALY

MARION E. ALBERTS, M.D.
SCIENTIFIC EDITOR

OLD AGE

"For just as I approve of the young man in whom there is a touch of age, so I approve of the old man in whom there is the flavour of youth. He who strives thus to mingle youthfulness and age may grow old in body, but old in spirit he will never be." CICERO (101-43 BC): On Old Age, IX 38.

IT HAS BEEN SAID that few people know how to grow old. To do so has become increasingly important now that our life span has increased tremendously. This phenomenon of life extension has manifest social problems to a point of great concern to sociologists, economists and politicians. New styles of living are on the horizon, and society must become increasingly concerned for the welfare of the aged.

Cultures of the past looked upon the aged as the responsibility of the family or local tribe. As the elderly were relieved of the responsibilities of the hunt or doing battle, they served to relate fact and legend to the young. They also gave counsel to the society in the sense of a "wise sage" or arbitrator. The responsibility for the care and keep of the aged fell upon the immediate family or close associates. Some ethnic groups still hold to these tenets to a degree, and take elderly parents into the home of one of the children for loving care during their last days.

However, self-interest has entered more and more into our way of life. We see this not only in attitudes of public servants but among people as a whole in their relationships with

others. Recent strikes by government employees, e.g., police officers and fire-fighters, as well as physicians, represent a striking contrast (no pun intended) to the images held by predecessors. Once it was unthinkable for persons to consider such an act against their fellow citizens.

The aged may be proud. However, in many instances they need aid. We in medicine know that advances in health care are enabling people to live longer. Therefore, we must stand ready to provide for the needs of the elderly.

Then, in some instances, laws were promulgated to make such actions unlawful, though circumvention of the law appears to be a national pastime recently. Yet, these instances reflect themselves in our attitudes toward the aged, and often the aged one is trapped by the same attitude.

Legislative action provides a form of security for the aged. We have the audacity to call it "Social Security" . . . but is it? The young are being taxed more and more for their ultimate secure position in society. Therefore, their attitude becomes one of why should it be their responsibility to care for the aged members of their own family. After all, the government will take care of them. They should have saved, they have retirement plans, and furthermore the young have their own problems and self-interests.

We are a mobile, restless culture. There is an increasing desire for self-gratification with strong pressures by our fellow citizens to accumulate wealth and material gain. There is nothing wrong with that except in the way it is done. How does one equate self-esteem and moral turpitude with lack of concern for others? By continuing attitudes of avarice and greed?

The aged may be proud. However, in many instances they need aid. We in medicine know that advances in health care are enabling people to live longer. Therefore, we must stand ready to provide for the needs of the elderly. As professionals on whom much responsibility is placed, we must devote our efforts conscientiously to the well being of the aged. We must do this as physicians as well as members of society as a whole. — M.E.A.

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OUR MAN ON EDUCATION

RICHARD M. CAPLAN, M.D.

OF SCIENCE AND SORCERY

HOW OFTEN do you think, when prescribing a drug or suggesting surgery, that your ministrations depend upon your *faith* in their expected usefulness. And what is the basis of that faith; what entitles you to the optimism of your prediction? Is it not that you are a believer in SCIENCE? Of course, you say, isn't everyone? The answer is a very strong *NO*. In fact, a tally of the views of essentially all living humans shows how small the role science plays in what most people believe. Even among the small segment of the earth's peoples who think that illness results from natural, rather than supernatural, causes, they are likely to credit stress, deterioration or accident (including overt human aggression), while a few sophisticated ones would identify infection.

All of these are capable of explanations congenial to modern science. In a way more interesting are the many societies that explain illness by a variety of supernatural mechanisms. Those cultures are discussed in an interesting book, *Theories of Illness, A World Survey*, by a distinguished anthropologist, George Murdock (published in 1980 by the University of Pittsburgh Press). He describes: fate (astrological influences, individual predestination); ominous sensations (dreams and other sensory stimulation thought to cause, as well as portend, illness); contagion (not germs, but contact with a "purportedly polluting object, substance or person" — but not including poisoning), mystical retribution (illness direct-

ly generated by the breaking of a taboo, especially taboos involving food, sex, etiquette, ritual, property or speech); soul loss (by its voluntary wandering, not its capture); spirit aggression (direct hostile action by a malevolent or affronted supernatural entity: ghost, spirit, demon); sorcery (impaired health due to aggressive magical technique by a human being); and finally, witchcraft (aggressive action by a "special class of humans believed to be endowed with a special power or propensity for evil").

Murdock came to these categories after anthropological field study of 186 societies scattered worldwide. Such work must be done by an anthropologist because modern "medical scientists" don't "believe" in supernatural causes and are thus disinclined to study this crucial variable that guides the nature of the doctor-patient relationship, as well as often the ultimate health outcome.

One of the reasons traditionally offered for medicine's acceptance of science is its success in predicting. We can predict how long it will take a (frictionless) car to roll down an inclined plane; likewise, how many milligrams of intravenous sodium pentothal will be needed to induce anesthesia in a normal 30-year-old male weighing 175 pounds. Fate, ghosts and sorcery are much less certain than that in their operations. What seems amazing at all is the extent to which these malevolent influences appear predictable and controllable in individuals who espouse them — for example, that violation of a taboo may produce a particular ill result.

READING SOME medical anthropology can be engrossing, and it can make us wonder, at least fleetingly, whether what we really think is so, is so. And in truth, if we understand it rightly, we realize that Science doesn't prove something *is* so. Rather, it can prove that certain things seem *not* to be so, and amasses evidence that points very strongly toward the "real truth" of some fact or generalization. If that presumed truth permits repeated and accurate prediction, then we believe it until a "better" truth comes along. Thus, we experience the coming and going of new truths and methods, e.g. gastric freezing for peptic ulcer disease.

But we need to remind ourselves of the

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Dr. Caplan is Associate Dean for Continuing Medical Education at The University of Iowa College of Medicine.



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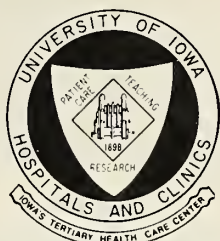
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DRUG THERAPY REVIEW



UNIVERSITY OF IOWA HOSPITALS AND CLINICS

REYNOLD SPECTOR, M.D., Editor

THE TREATMENT OF FEVER

PATIENTS ARE sometimes admitted to the hospital for evaluation of prolonged high fevers. Often, the cause of the fever is not immediately discernible and the patient continues to have high fevers for several days. This scenario frequently prompts the patient's physician to order antipyretics, usually on a "p.r.n." basis for fevers greater than, say, 39°C, solely to reduce the fever.

What is the goal of the administration of antipyretics in this situation? With few exceptions, the presence of fever does not in itself present any serious risk to the patient, and patients with febrile illnesses rarely die as a result of the adverse effects of elevated body temperatures.¹ Only in situations such as fever-induced status epilepticus, heat stroke, and malignant hyperthermia is the body temperature elevated to such an extent that damage to sensitive tissues occurs; in those situations, measures to reduce the fever are an

integral part of patient care and antipyretics are inadequate. Other conditions in which the fever per se is thought to be harmful to the patient include fever in the patient with heart failure and in the young child who may be at risk of febrile convulsions. Although the increased cardiorespiratory demands imposed by generation of fever may indeed precipitate cardiac failure in an occasional patient, it does so only rarely and none of the series of patients with fevers of unknown origin that we have seen even mention this possible complication of fever. Similarly, prevention of febrile convulsions in children by administration of antipyretics is a rationale for use of antipyretics which is not well supported in the literature. No more than 4% of children with fevers get febrile convulsions. Of that small fraction, seizures are the first overt sign of illness in almost one-third and less than 2% suffer febrile status epilepticus. Most importantly, there are no published data to indicate that antipyretics have a beneficial effect in this setting.²

There is a substantial body of experimental evidence suggesting that, in a variety of animal species, fever is an important aspect of host defenses against pathogenic organisms.³ Animals that are incapable of regulating their own body temperature migrate to warmer areas of their enclosures after infection, and prevention of that passive warming increases the lethality of the infection.⁴ This phenomenon has been best studied in lizards, in whom mortality from bacterial infection is markedly increased either by not providing a heat source or by abrogating heat-seeking behavior by administration of salicylates.⁵ These effects are not due to direct killing of the bacteria by higher temperatures but appear to be mediated by complex alterations in host defenses and bacterial metabolism.⁶ Although similar data indicating benefit from fever or harm from antipyretics are not available for man, it is prudent to recall that one of the first Nobel Prizes in medicine was awarded to von Jauregg for his discovery that induced fevers cured a substantial number of patients with neurosyphilis and that antipyretics were considered to be contraindicated in patients with typhus and typhoid fever by clinicians in the preantibiotic era.⁷

Thus, since fever is usually not harmful and may be of value in controlling the process which was responsible for development of fe-

This information for Iowa physicians is furnished and sponsored by the University of Iowa Hospitals and Clinics.

ver, the only possible goal of any efforts to reduce fever in the vast majority of patients is to increase patient comfort. In adults, this is almost certainly not accomplished by "p.r.n." administration of antipyretics. Such a mode of administration converts a pattern of prolonged fever to a pattern of alternating sweats, rigors, and recurrent fever.¹ For adults, we suggest that regular, for example, every 4 to 6 hours, administration of salicylates or acetaminophen is preferable, when it has been decided that reduction of fever while diagnostic evaluations are ongoing would significantly improve the patient's well-being. The antipyretics can be discontinued every few days to determine if the fever persists and certainly should be discontinued if the patient is not impressed with any symptomatic benefits.

In children, on the other hand, continuous administration of salicylates can be extremely hazardous since toxic levels can rapidly accumulate.⁸ In the pediatric patient, the use of

"p.r.n." antipyretics is probably preferable, but such therapy should be administered to make the child more comfortable and not for the sole and simple purpose of fever reduction.

Fever is not a manifestation of disease that must be treated just because it's there. — *Edward Pesanti, M.D., Assistant Professor of Medicine, and Robert Roberts, M.D., Professor of Pediatrics and Pharmacology.*

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OUR MAN ON EDUCATION

(Continued from page 497)

essentially metaphysical, even religious, nature of our faith in science. Science (for example, antibiotics) may "work" even for a patient who believes the illness is due to a violated taboo or insult to a respected demon or god. And if we probed more carefully into the belief systems of our patients, we might become better predictors of the likely therapeutic or placebo effects of our remedies.

Murdock, discussing psychological phenomena, provokes us thus: "It is perhaps unnecessary to insist that, unlike the physical and social environments, the ideational environment is totally illusory and has no actual existence outside of peoples' minds: There are, for example, no such things as souls, spirits, or demons, and such mental constructs as Jehovah are as fictitious as are those of Superman or Santa Claus. Neither ghosts nor gods exert the slightest influence on men or their behavior. But men can and do influence the behavior of one another, and the ideas they hold can have a serious bearing on how they behave. The Crusades, the Inquisition, and Hitler's 'holocaust' illustrate, not strictly the power of ideas, but the influence that can be exerted by men who hold particular ideas."

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STATE DEPARTMENT/ PUBLIC HEALTH

WELL ELDERLY CLINICS

THE Iowa Medical Society House of Delegates has expressed concern the past two years about the well elderly clinics in Iowa. The IMS Committee on Aging and Chronic Illness is reviewing these concerns with the Iowa State Department of Health. A JOURNAL article has been suggested to provide background information on the well elderly clinics.

Chapter 110, Acts of the 1975 Session of the Sixty-Sixth Iowa General Assembly placed in effect (and funded) a variety of programs for elderly or handicapped Iowans. The section covering well elderly clinics states: "A well elderly clinic is a clinic for the development of a program of preventive medicine to serve persons 60 years of age and older." The initial appropriation of \$150,000 has been followed by annual appropriations (for FY 82 the appropriation is \$202,248). The entire appropriation is for local grants, with no funds provided to the State Health Department to monitor or consult.

The current appropriation provides some support to 15 projects which serve 22 counties. There are several well elderly clinics in the state which do not receive funding from the Iowa State Department of Health. The services are usually provided by local boards of health or visiting nurse associations. Standards and recommendations have been developed for the funded projects. These standards require a local advisory committee to include one or more

physicians. The committee (1) helps plan the clinic activities, (2) provides guidance to the program, and (3) is responsible for objective evaluation. It is required that rapport be established with family practitioners, internists and other physicians who see the elderly to ensure adequate referrals and follow-up of persons seen in the clinics.

In a typical clinic operation, appointments are made for persons to come either to a permanent site or to a variable community site (church). At the clinic a nurse with additional training in adult health assessment takes an extensive health history and does a physical assessment. Minimal laboratory work (at least blood sugar, hemoglobin, urinalysis, and stool for blood) is also completed. The person is told of the findings of the history, assessment and laboratory work and provided recommendations (see their physician or dentist, have a recheck by the public health nurse, seek assistance from a special program, etc.). If they are referred for care or follow-up, a contact is made after an appropriate interval to assure the patient has secured the necessary assistance.

A public health nurse associated with one of the projects has observed that the persons who come to the clinic usually fit into one of three categories:

1. Those who have been to their physician in the past year or few years and are on some type of long-term treatment. They have, however, not returned to the physician for follow-up and have not continued the treatment. The reasons for not having continued vary from "just didn't think to go back" or "couldn't see where the medicine was doing all that much for me" or "didn't understand why I had to keep going back so I quit going" to "I can't afford it." The importance of continued physician follow-up can be stressed to these persons.

2. Those who have not been to a physician for a long time because they feel "well" but have questions about how to maintain their state of wellness and do not want to bother their doctor for a check-up.

3. Those who know they have an acute problem or a serious chronic problem that needs attention; they need someone to reinforce what they already know about their problem and to urge them to do something about it. This sometimes involves several follow-up

STATE DEPARTMENT/PUBLIC HEALTH

(Continued from page 501)

contacts to convince the person of the necessity of seeing their physicians for care.

Each of these types of individuals can benefit from a well elderly clinic. The specific role of the clinic varies in each of these instances but it always involves the common characteristics of thorough assessment, health education and appropriate referral.

Health education is a key component of well elderly clinics. This is done on a one-to-one basis and is supplemented with take-home printed materials. It is valuable (1) for the persons with specific problems which led to referral and treatment, and (2) for those who did not need to be referred. The health education can include a wide variety of components,

such as: very specific instruction covering questions the patient may have about current treatment or symptoms; instruction in specific preventive measures; instruction on the importance of following the physician's orders in long-term chronic disease treatment, even if the individual feels well; general health education in such areas as nutrition and home safety; caution regarding the mixing of different drugs from different sources; general information about diseases and symptoms and information about the health and social resources available in the community.

The physicians in some communities have found well elderly clinics to be a valuable adjunct to their medical services. To be of most value, the clinic programs need to be well planned and conducted. The input of community physicians through the advisory committee and through direct feedback is essential.

September 1981 Morbidity Report

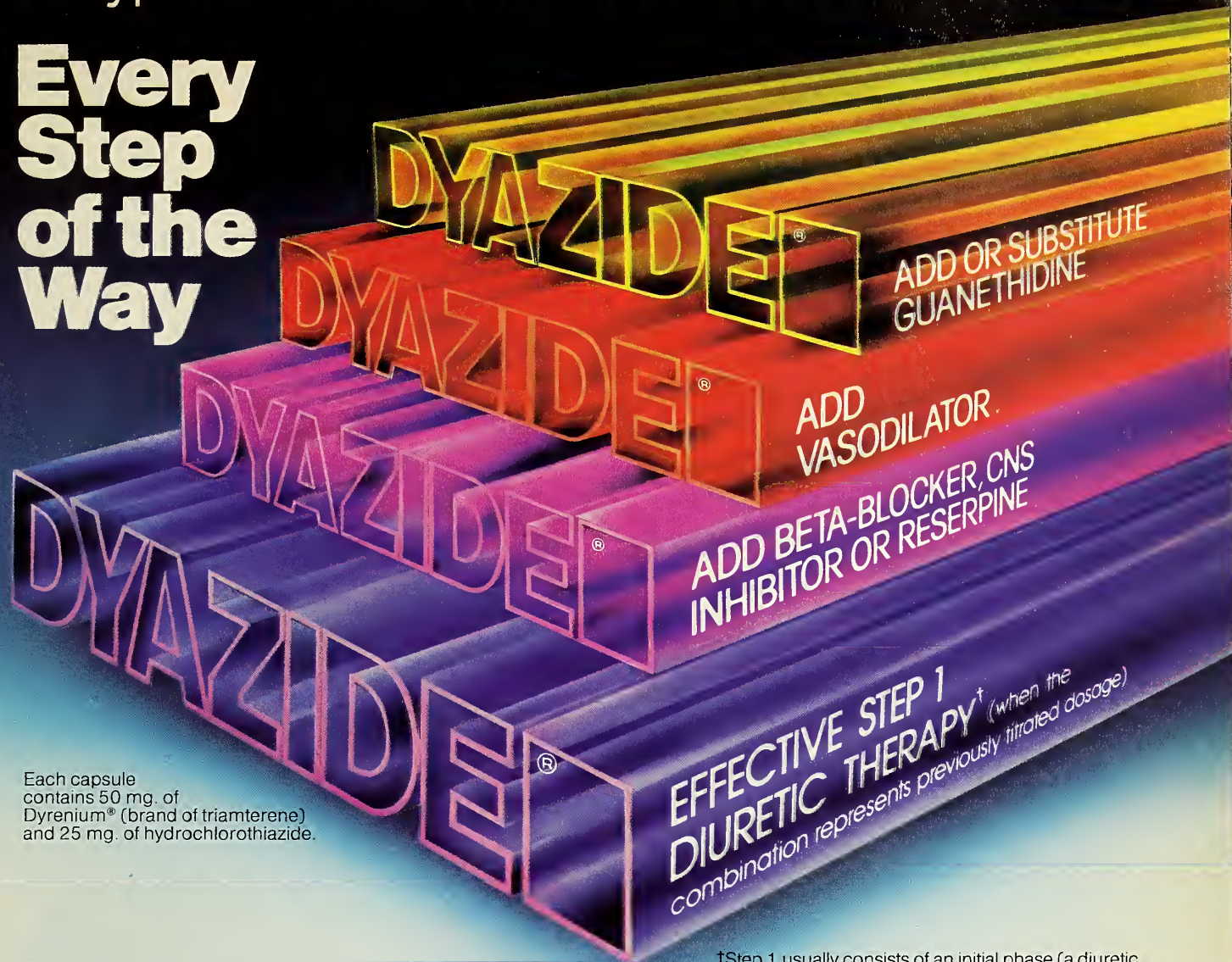
Disease	Sept. 1981 Total	1981 to Date	1980 to Date	Most Sept. Coses Reported From These Counties
Amebiasis	5	17	9	Polk
Brucellosis	0	1	5	
Chickenpox	43	7032	7480	Bueno Visto, Linn, Polk
Cytomegalovirus	5	23	18	Johnson, Linn, Polk
Eaton's Agent infection	5	24	13	Hordin, Iowa, Johnson
Encephalitis, virol	4	18	16	Dubuque, Linn, Polk
Erythema infectiosum	1	1153	404	Polk
Gastroenteritis (GIV)	609	12850	14345	Polk, Linn, Buchanan
Giardiasis	34	87	27	Polk
Hepatitis, A	5	174	131	Linn, Polk, Tomo
Hepatitis, B	8	68	71	Polk
type unspecified	5	46	57	Johnson, Dubuque
Herpes Simplex	37	188	80	Dubuque, Johnson, Linn
Herpes Zoster	0	4	1	
Histoplasmosis	2	9	21	Polk
Infectious mononucleosis	21	211	252	Linn, Story, O'Brien
Influenza, lab confirmed	0	191	110	
Influenza-like illness (URI)	1442	50407	51266	Linn, Johnson, Polk
Meningitis aseptic	14	58	36	Polk, Boone, Bueno Visto

Disease	Sept. 1981 Total	1981 to Date	1980 to Date	Most Sept. Coses Reported From These Counties
bacterial meningococcal	8	94	97	Polk, Sioux Scott
Mumps	3	46	43	Polo Alto, Polk, Story
Pertussis	2	5	2	Johnson, Lee
Robies in animals	84	718	352	Benton, Jasper, Story
Rheumatic fever	0	7	0	
Rubella (German measles)	0	4	8	
Measles	0	1	20	
Salmonellosis	18	193	120	Linn, Scott
Shigellosis	3	26	41	Scott, Tomo, Woodbury
Tuberculosis				
total ill	2	71	63	Muscatine, Scott
bact. pos.	2	45	46	Muscatine, Scott
Venereal diseases:				
Gonorrhea	441	3824	3694	Polk, Block Hawk, Linn
Syphilis	3	19	14	Wapello, Scott

Laboratory Virus Diagnosis Without Specified Clinical Syndrome: Guillain-Borre — 1, Davis, 2, Muscatine; Legionnaire's — 1, Scott; Rocky Mt. Spotted Fever — 1, Boone, 1, Polk; Scarlet Fever — 2, Polk; Ascariasis — 1, Johnson, 2, Scott; Clonorchis sinensis — 3, Humboldt, 1, Scott, 1, Sioux; Echovirus — 1, Cedar, 1, Polk, 1, Scott; Coxsackie — 1, Boone, 1, Clinton, 3, Dubuque, 3, Polk, 1, Scott; Malaria — 1, Woodbury; Complobacter — 1, Buchanan, 1, Cherokee, 8, Dubuque, 1, Foyette, 1, Morion, 1, Marshall, 4, Polk, 1, Poweshiek, 2, Tomo; Toxic Shock Synd. — 1, Johnson.

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Each capsule contains 50 mg. of Dyrenium® (brand of triamterene) and 25 mg. of hydrochlorothiazide.

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Serum K⁺ and BUN should be checked periodically (see Warnings).

Before prescribing, see complete prescribing information in SK&F Co. literature or PDR. The following is a brief summary.

*** WARNING**

This drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual. If this combination represents the dosage so determined, its use may be more convenient in patient management. Treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

Contraindications: Further use in anuria, progressive renal or hepatic dysfunction, hyperkalemia. Pre-existing elevated serum potassium. Hypersensitivity to either component or other sulfonamide-derived drugs.

Warnings. Do not use potassium supplements, dietary or otherwise, unless hypokalemia develops or dietary intake of potassium is markedly impaired. If supplementary potassium is needed, potassium tablets should not be used. Hyperkalemia can occur, and has been associated with cardiac irregularities. It is more likely in the severely ill, with urine volume less than one liter/day, the elderly and diabetics with suspected or confirmed renal insufficiency. Periodically, serum K⁺ levels should be determined. If hyperkalemia develops, substitute a thiazide alone, restrict K⁺ intake. **Associated widened QRS complex or arrhythmia requires prompt additional therapy.** Thiazides cross the placental barrier and appear in cord blood. Use in pregnancy requires weighing potential benefits against possible hazards, including fetal or neonatal jaundice, thrombocytopenia, other adverse reactions seen in adults. Thiazides appear and

triamterene may appear in breast milk. If their use is essential, the patient should stop nursing. Adequate information on use in children is not available. Sensitivity reactions may occur in patients with or without a history of allergy or bronchial asthma. Possible exacerbation or activation of systemic lupus erythematosus has been reported with thiazide diuretics.

Precautions: Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids). Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics or those with suspected or confirmed renal insufficiency. Watch for signs of impending coma in severe liver disease. If spironolactone is used concomitantly, determine serum K⁺ frequently; both can cause K⁺ retention and elevated serum K⁺. Two deaths have been reported with such concomitant therapy (in one, recommended dosage was exceeded, in the other, serum electrolytes were not properly monitored). Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving triamterene, and leukopenia, thrombocytopenia, agranulocytosis and aplastic anemia have been reported with thiazides. Triamterene is a weak folic acid antagonist. Do periodic blood studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients. The following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis. 'Dyazide' interferes with fluorescent measurement of quinidine. Hypokalemia is uncommon with 'Dyazide', but should it develop, corrective measures should be taken such as potassium supplementation or increased

dietary intake of potassium-rich foods. Corrective measures should be instituted cautiously and serum potassium levels determined. Discontinue corrective measures and 'Dyazide' should laboratory values reveal elevated serum potassium. Chloride deficit may occur as well as dilutional hyponatremia. Serum PBI levels may decrease without signs of thyroid disturbance. Calcium excretion is decreased by thiazides. 'Dyazide' should be withdrawn before conducting tests for parathyroid function.

Diuretics reduce renal clearance of lithium and increase the risk of lithium toxicity.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth, anaphylaxis, rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting, diarrhea, constipation, other gastrointestinal disturbances. Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and, rarely, allergic pneumonitis have occurred with thiazides alone. Triamterene has been found in renal stones in association with other usual calculus components. Rare incidents of acute interstitial nephritis and of impotence have been reported with the use of 'Dyazide', although a causal relationship has not been established.

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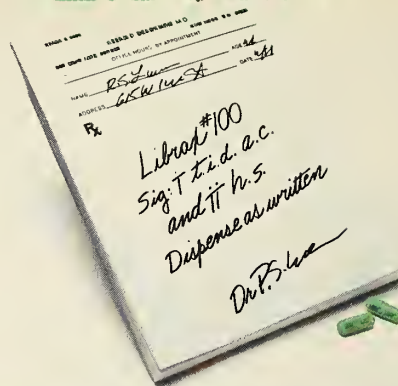
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Each capsule contains 5 mg chlordiazepoxide HCl and 2.5 mg clidinium Br.

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Contraindications: Glaucoma, prostatic hypertrophy, benign bladder neck obstruction; hypersensitivity to chlordiazepoxide HCl and/or clidinium bromide.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants, and against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Physical and psychological dependence rarely reported on recommended doses, but use caution in administering Librium® (chlordiazepoxide HCl/Roche) to known addiction-prone individuals or those who might increase dosage, withdrawal symptoms (including convulsions) reported following discontinuation of the drug.

Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy. Advise patients to discuss therapy if they intend to or do become pregnant.

As with all anticholinergics, inhibition of lactation may occur.

Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude ataxia, oversedation, confusion (no more than 2 capsules/day initially, increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacology of agents, particularly potentiating drugs such as MAO inhibitors, phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions reported in psychiatric patients. Employ usual precautions in treating anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation reported very rarely in patients receiving the drug and oral anticoagulants, causal relationship not established.

Adverse Reactions: No side effects or manifestations not seen with either compound alone reported with Librax. When chlordiazepoxide HCl is used alone, drowsiness, ataxia, confusion may occur, especially in elderly and debilitated, avoidable in most cases by proper dosage adjustment, but also occasionally observed at lower dosage ranges. Syncope reported in a few instances. Also encountered: isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent, generally controlled with dosage reduction; changes in EEG patterns may appear during and after treatment, blood dyscrasias (including agranulocytosis), jaundice, hepatic dysfunction reported occasionally with chlordiazepoxide HCl, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax typical of anticholinergic agents, i.e., dryness of mouth, blurring of vision, urinary hesitancy, constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.



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References: 1. Sullivan MA, Cohen S, Snape WJ. *N Engl J Med* 298:878-883, Apr 20, 1978.
2. Snape WJ et al. *Gastroenterology* 72: 383-387, Mar 1977.

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INDICATIONS AND USAGE

For the prevention and treatment of nocturnal recumbency leg muscle cramps

CONTRAINDICATIONS

Quinamm may cause fetal harm when administered to a pregnant woman. Congenital malformations in the human have been reported with the use of quinine, primarily with large doses (up to 30 g.) for attempted abortion. In about half of these reports the malformation was deafness related to auditory nerve hypoplasia. Among the other abnormalities reported were limb anomalies, visceral defects, and visual changes. In animal tests, teratogenic effects were found in rabbits and guinea pigs and were absent in mice, rats, dogs, and monkeys. Quinamm is contraindicated in women who are or may become pregnant. If this drug is used during pregnancy, or if the patient becomes pregnant while taking this drug, the patient should be apprised of the potential hazard to the fetus. Because of the quinine content, Quinamm is contraindicated in patients with known quinine hypersensitivity and in patients with glucose-6-phosphate dehydrogenase (G-6-PD) deficiency.

Since thrombocytopenic purpura may follow the administration of quinine in highly sensitive patients, a history of this occurrence associated with previous quinine ingestion contraindicates its further use. Recovery usually occurs following withdrawal of the medication and appropriate therapy.

This drug should not be used in patients with tinnitus or optic neuritis or in patients with a history of blackwater fever.

WARNINGS

Repeated doses or overdosage of quinine in some individuals may precipitate a cluster of symptoms referred to as cinchonism. Such symptoms, in the mildest form, include ringing in the ears, headache, nausea, and slightly disturbed vision; however, when medication is continued or after large single doses, symptoms also involve the gastrointestinal tract, the nervous and cardiovascular systems, and the skin.

Hemolysis (with the potential for hemolytic anemia) has been associated with a G-6-PD deficiency in patients taking quinine. Quinamm should be stopped immediately if evidence of hemolysis appears.

If symptoms occur, drug should be discontinued and supportive measures instituted. In case of overdosage, see OVERDOSAGE section of prescribing information.

PRECAUTIONS

General

Quinamm should be discontinued if there is any evidence of hypersensitivity (See CONTRAINDICATIONS). Cutaneous flushing, pruritus, skin rashes, fever, gastric distress, dyspnea, ringing in the ears, and visual impairment are the usual expressions of hypersensitivity, particularly if only small doses of quinine

have been taken. Extreme flushing of the skin accompanied by intense, generalized pruritus is the most common form. Hemoglobinuria and asthma from quinine are rare types of idiosyncrasy.

In patients with atrial fibrillation, the administration of quinine requires the same precautions as those for quinidine. (See Drug Interactions.)

Drug Interactions

Increased plasma levels of digoxin and digitoxin have been demonstrated in individuals after concomitant quinine administration. Because of possible similar effects from use of quinine, it is recommended that plasma levels for digoxin and digitoxin be determined for those individuals taking these drugs and Quinamm concomitantly.

Concurrent use of aluminum-containing antacids may delay or decrease absorption of quinine.

Cinchona alkaloids, including quinine, have the potential to depress the hepatic enzyme system that synthesizes the vitamin K-dependent factors. The resulting hypoprothrombinemic effect may enhance the action of warfarin and other oral anticoagulants.

The effects of neuromuscular blocking agents (particularly pancuronium, succinylcholine, and tubocurarine) may be potentiated with quinine, and result in respiratory difficulties.

Urinary alkalinizers (such as acetazolamide and sodium bicarbonate) may increase quinine blood levels with potential for toxicity.

Drug Laboratory Interactions

Quinine may produce an elevated value for urinary 17-ketogenic steroids when the Zimmerman method is used.

Carcinogenesis, Mutagenesis, Impairment of Fertility

A study of quinine sulfate administered in drinking water (0.1%) to rats for periods up to 20 months showed no evidence of neoplastic changes.

Mutation studies of quinine (dihydrochloride) in male and female mice gave negative results by the micronucleus test. Intraperitoneal injections (0.5 mM/kg.) were given twice, 24 hours apart. Direct *Salmonella typhimurium* tests were negative, when mammalian liver homogenate was added, positive results were found.

No information relating to the effect of quinine upon fertility in animal or in man has been found.

Pregnancy

Category X. See CONTRAINDICATIONS.

Nonteratogenic Effects

Because quinine crosses the placenta in humans, the potential for fetal effects is present. Stillbirths in mothers taking quinine have been reported in which no obvious cause for the fetal deaths was shown. Quinine in toxic amounts has been associated with abortion. Whether this action is always due to direct effect on the uterus is questionable.

Nursing Mothers

Caution should be exercised when Quinamm is given to nursing women because quinine is excreted in breast milk (in small amounts).

ADVERSE REACTIONS

The following adverse reactions have been reported with Quinamm in therapeutic or excessive dosage. (Individual or multiple symptoms may represent cinchonism or hypersensitivity.)

Hematologic: acute hemolysis, thrombocytopenic purpura, agranulocytosis, hypoprothrombinemia.

CNS: visual disturbances, including blurred vision with scotomata, photophobia, diplopia, diminished visual fields, and disturbed color vision; tinnitus, deafness, and vertigo; headache, nausea, vomiting, fever, apprehension, restlessness, confusion, and syncope.

Dermatologic/allergic: cutaneous rashes (urticarial), the most frequent type of allergic reaction; papular or scarlatiniform; pruritus; flushing of the skin; sweating; occasional edema of the face.

Respiratory: asthmatic symptoms.

Cardiovascular: anginal symptoms.

Gastrointestinal: nausea and vomiting (may be CNS-related); epigastric pain.

DRUG ABUSE AND DEPENDENCE

Tolerance, abuse, or dependence with Quinamm has not been reported.

OVERDOSAGE

See prescribing information for a discussion on symptoms and treatment of overdose.

DOSAGE AND ADMINISTRATION

1 tablet upon retiring. If needed, 2 tablets may be taken nightly—1 following the evening meal and 1 upon retiring.

After several consecutive nights in which recumbency leg cramps do not occur, Quinamm may be discontinued in order to determine whether continued therapy is needed.

Product Information as of October, 1980.

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ABOUT IOWA PHYSICIANS

Dr. W. H. Verduyn, a family practice physician in Reinbeck since 1961, has been appointed director of the rehabilitation unit at Schoitz Memorial Hospital in Waterloo. Dr. Verduyn received his medical training at the University of Amsterdam, the Netherlands. In 1976, he was awarded the first fellowship in spinal cord and brain injuries at the Rocky Mountain Spinal Cord Injury Center, Craig Hospital, Englewood, Colorado. . . . **Dr. Harlan Berthelsen**, Rock Valley, retired from medical practice in August. Dr. Berthelsen received the M.D. degree at the University of Kansas School of Medicine; interned at Providence Hospital in Kansas City, Kansas and St. John's Hospital in Tulsa, Oklahoma. At a recent open house, the local chamber of commerce presented Dr. Berthelsen a plaque commemorating his years of service to Rock Valley residents. . . . **Dr. James Widmer** and **Dr. Linwood Miller** have assumed the medical practice of **Drs. Phillip** and **Mary Couchman** in Mt. Pleasant. Dr. Widmer received the M.D. degree at U. of I. College of Medicine and completed his family practice residency at Mercy-St. Luke's in Davenport. Dr. Miller received his medical training at the College of Osteopathic Medicine and Surgery in Des Moines and completed his family practice residency in Mason City. Dr. Phillip Couchman is returning to the staff of the University of Iowa Hospitals and Dr. Mary Couchman is retiring from medical practice.

Dr. William Buhrow, Clinton, was guest speaker at a recent meeting of Ostomate Support Group in Clinton. Dr. Buhrow's presentation included a discussion of the anatomy and physiology of the alimentary tract with emphasis on the different types of ileostomies and colostomies. . . . **Dr. Charles B. Preacher**, Davenport, has been elected to the board of

trustees of the Putnam Museum. Dr. Preacher is a past president of the medical staff at St. Luke's Hospital and the Scott County Medical Society. . . . **Dr. Paul D. Anderson**, **Dr. Gary R. Melvin** and **Dr. Dale R. Wassmuth** recently were admitted to the three-year residency program at the Cherokee Mental Health Institute. Dr. Anderson received his medical training at the College of Osteopathic Medicine and Surgery in Des Moines; Dr. Melvin received his medical degree from the University of South Dakota School of Medicine and Dr. Wassmuth is a graduate of the U. of I. College of Medicine. . . . **Drs. Joanna Whalen** and **Teresa Eckhart** recently opened an obstetrics and gynecology practice in Dubuque. Both received their M.D. degrees at U. of I. College of Medicine where they also completed their residencies.

Dr. Phillip I. Crew, Cedar Rapids, is a recent recipient of the 1981 Founders Award presented by St. Luke's Health Care Foundation

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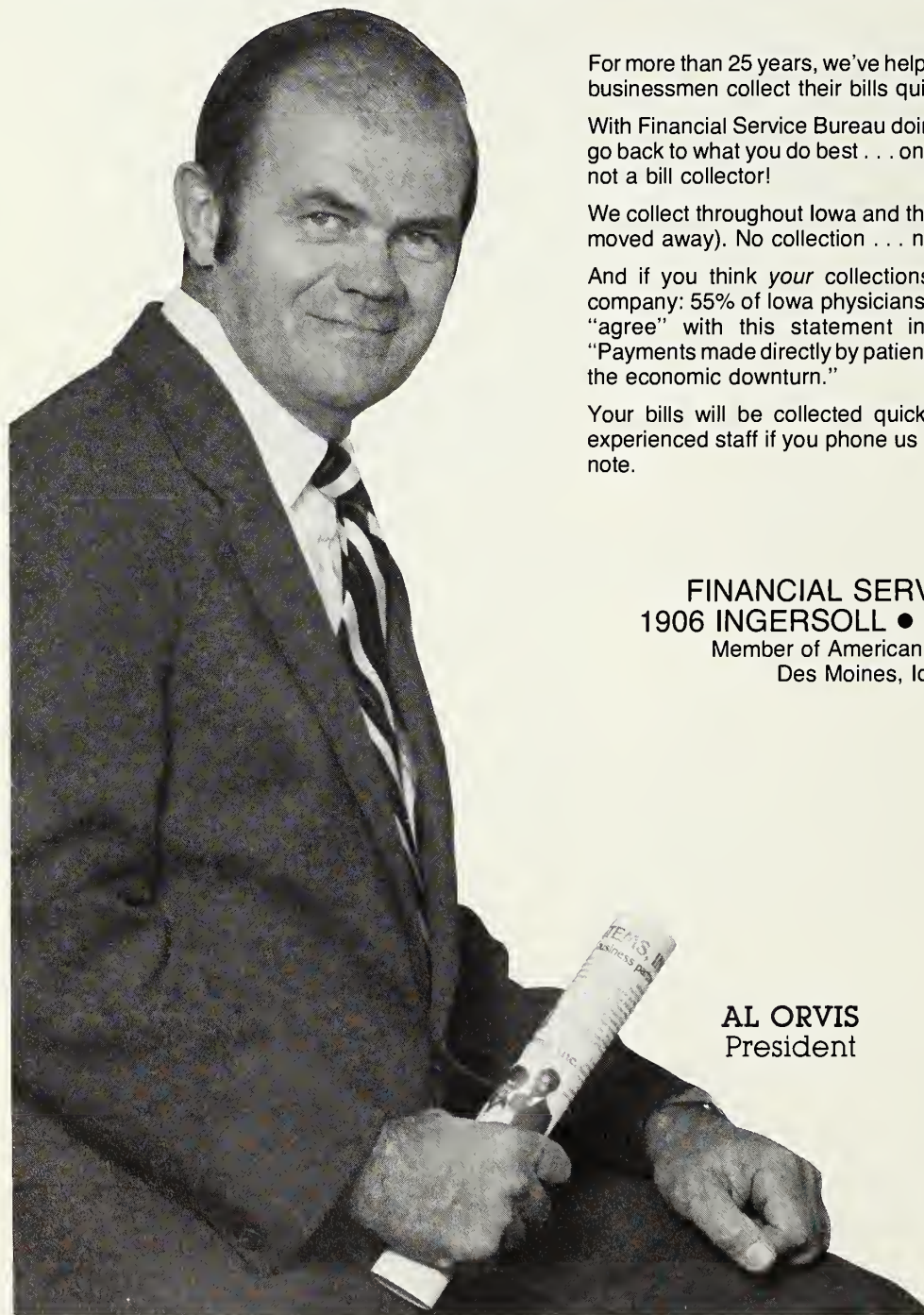
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in Cedar Rapids. Dr. Crew was cited for his leadership, volunteerism and involvement in health care in Eastern Iowa. Dr. Crew received the M.D. degree at the U. of I. College of Medicine; interned at Swedish Hospital, Seattle, Washington and began his medical practice in the Cedar Rapids-Marion area in 1934. He is a fellow of the American College of Surgeons and American College of Obstetrics and Gynecology. . . . **Dr. Maynardo Magtibay** began family practice in Mt. Ayr in September. Dr. Magtibay received his medical education in the Philippines at the University of St. Thomas; interned at Sioux Valley Hospital in Sioux Falls, South Dakota and completed his family practice residency at Midway Hospital and Children's Memorial Hospital in St. Paul, Minnesota. . . . At a recent meeting of the Iowa Thoracic Society, **Dr. Richard Corton**, Waterloo, was elected president, **Dr. Greg Hicklin**, Des Moines, president-elect; and **Dr. James Boddicker**, Cedar Rapids, secretary-treasurer.

Dr. Robert M. Kuhl, Creston, was guest speaker at a recent meeting of the Midwest Surgical Association. His clinical research paper on "Operative Cholangiomanometry as a Guide to Common Duct Exploration," was one of three selected for presentation from 27 resident papers submitted. The article will be published in the *American Surgeon* in the near future. Dr. Kuhl recently completed a surgery residency at Iowa Methodist Medical Center in Des Moines and has joined the Creston Medical Clinic. . . . **Drs. Glenn Van Roekel** and **Monte Russell**, LeMars physicians, are co-chairman of the 1981 Western Iowa for Westmar College fund drive. . . . **Dr. Arnold Delbridge**, Cedar Falls, was guest speaker at a recent meeting for athletes, parents and coaches at Sartori Memorial Hospital. Dr. Delbridge spoke on sports safety. . . . **Dr. Kenneth Lister**, Ottumwa, recently was honored at a retirement-recognition tea at Ottumwa Hospital. Dr. Lister received a gift from the hospital staff and \$10,000 from the Wapello County Medical Society to be presented to the hospital in his name. Dr. Lister retired from active practice in July. He is still working on a consulting basis at the Ottumwa Medical Clinic. . . . **Dr. Galen Van Wyhe** recently joined **Drs. Richard Honderick** and **Steven Ferguson** in Rock Rapids. A Rock Rapids native, Dr. Van Wyhe received the M.D. degree and completed his

internal medicine residency at the U. of I. College of Medicine.

Sioux City physicians **Drs. Richard B. Rubenstein**, cardiologist; **Horst G. Blume**, neurologist; **Liem-Som Oei**, internist, and **Cesar H. Rojas**, neurologist, have opened heart, hypertension, kidney and pain clinics in Fort Dodge and Sac City. The clinics are described as "out-reach programs" wherein specialists from Sioux City will offer their services in Fort Dodge and Sac City. Each of the four specialists will alternate days at the clinic. . . . **Dr. F. J. Neglia**, Maxwell, retired from medical practice in August. Dr. Neglia received the M.D. degree at Georgetown University School of Medicine in Washington, D.C. and began his medical practice in Maxwell in 1946. He is a charter fellow of the American Academy of Family Physicians and American Geriatric Society. Residents of the area recently held an open house honoring Dr. and Mrs. Neglia. . . . **Dr. David C. Carver**, Rockwell City, retired in October. Dr. Carver received the M.D. degree at U. of I. College of Medicine and began medical practice in Rockwell City in 1939. . . . **Dr. Abdul L. Chughtai**, Des Moines, recently attended a workshop on "Demonstrations in Percutaneous Transluminal Coronary Angioplasty" in Atlanta, Georgia. The course was directed by Dr. Andera Gruentzig of the Emory University School of Medicine. . . . **Dr. Edward Hertko**, Des Moines, was guest speaker at a recent meeting of the Siouxland Diabetes Chapter. His topic "Diabetes Update-1981." . . . **Dr. Walter W. Larson**, Ames, recently presented a lecture on "Life Threatening Rashes" at the Department of Pediatrics at the U. of I. College of Medicine.

Dr. Gary Skaletsky has joined **Dr. James LaMorgese** to practice neurosurgery in Cedar Rapids. Dr. Skaletsky received the M.D. degree at the University of Illinois School of Medicine; interned and served his neurosurgery residency at the University of Illinois Hospital. . . . **Dr. Brian F. Luepke** has joined **Drs. Tom D. Throckmorton** and **Wm. H. Myerly** to practice general surgery in Spencer. Dr. Luepke received the M.D. degree at the U. of I. College of Medicine and completed his surgery residency at the Iowa Methodist Medical Center and Broadlawns Medical Cen-

ter in Des Moines. . . . **Dr. Clare A. Trueblood**, Indianola, retired from medical practice in October. Dr. Trueblood received the M.D. degree at Temple University Medical School in Philadelphia, Pa., and interned at Iowa Methodist Hospital in Des Moines. He began medical practice in Indianola in 1936. Dr. and Mrs. Trueblood plan to remain in Indianola.

DEATHS

Dr. Louise M. Camel Farrage, 59, Council Bluffs obstetrician and gynecologist, died September 4. Dr. Farrage received the M.D. degree at Creighton University Medical School. She was a member of the National Federation of Business and Professional Women and a past member of the Creighton Medical Advisory Board of the Creighton Medical School. In 1980, she received an award from the National Catholic Education President's Board for Respect for Life in the field of obstetrics and gynecology. Survivors include her husband, **Dr. Edward Farrage**, Council Bluffs family practice physician.

Dr. Lawrence A. Miller, 83, longtime North English physician, died August 28 at Mercy Hospital in Iowa City. Dr. Miller received the M.D. degree and interned at U. of I. College of Medicine. He began his medical practice in North English in 1924, retiring in 1978. Dr. Miller was a life member of the Iowa Medical Society. Survivors include a son, **Dr. Lawrence A. Miller, II**, who began his medical practice in North English with his father.

Dr. Stanley W. Dusdieker, 76, West Des Moines, died September 18 at Mercy Hospital Medical Center in Des Moines. Dr. Dusdieker received the M.D. degree at U. of I. College of Medicine. He began medical practice in West Des Moines in 1930. Dr. Dusdieker was a life member of the Iowa Medical Society.

Dr. Paul Todd, 46, Knoxville, died September 22 at the Knoxville Area Community Hospital. Dr. Todd received the M.D. degree at the University of Missouri School of Medicine and interned at Parkland Memorial Hospital in Dallas, Texas. He joined the Mater Clinic in Knoxville in 1969.



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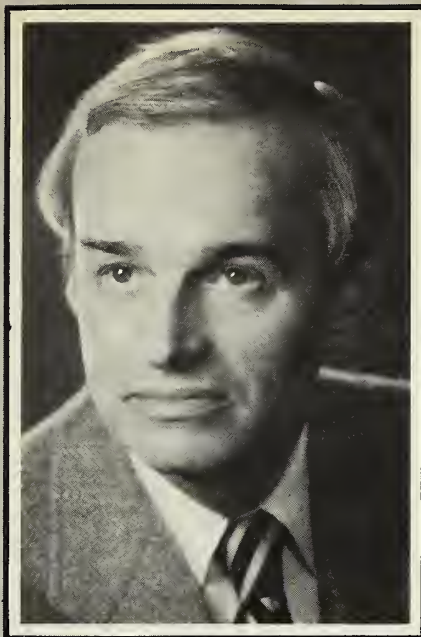
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PRESIDENT'S PRIVILEGE



IN SEPTEMBER THE DES MOINES REGISTER ran a series of articles on political action committees. This reporting effort addressed the pros and cons of PACs at some length. The series contained several references to data compiled by Common Cause, plus the views of its chairman. This self-righteous organization has been known for its crusade against PACs ever since these entities began to spread beyond the labor movement. As one would expect, Common Cause advocates public financing of political campaigns.

In the early days of this country economic interests tended to center on regional allegiances. This was recognized by the framers of the constitution when they created a bicameral legislature with state representation to include geographic and demographic factors. As the United States matured and increased in complexity, regional interests were joined and even superceded politically by those of similar occupational or professional endeavor. Labor, agriculture, business and professional groups began to pursue legislative interests with greater political activity. It is only logical for such groups to speak with a single voice whenever possible. And, obviously, PACs are a rational way for economically allied groups to impact on the governmental process.

Some flagrant abuses of PACs were reported by the *Register*. It goes without saying, as with any endeavor, where ill gain is evident, the

public should be wary and participation withheld. The *Register* series will have served a useful purpose if it caused persons to assure themselves they are participating in an ethical and bonafide political action organization.

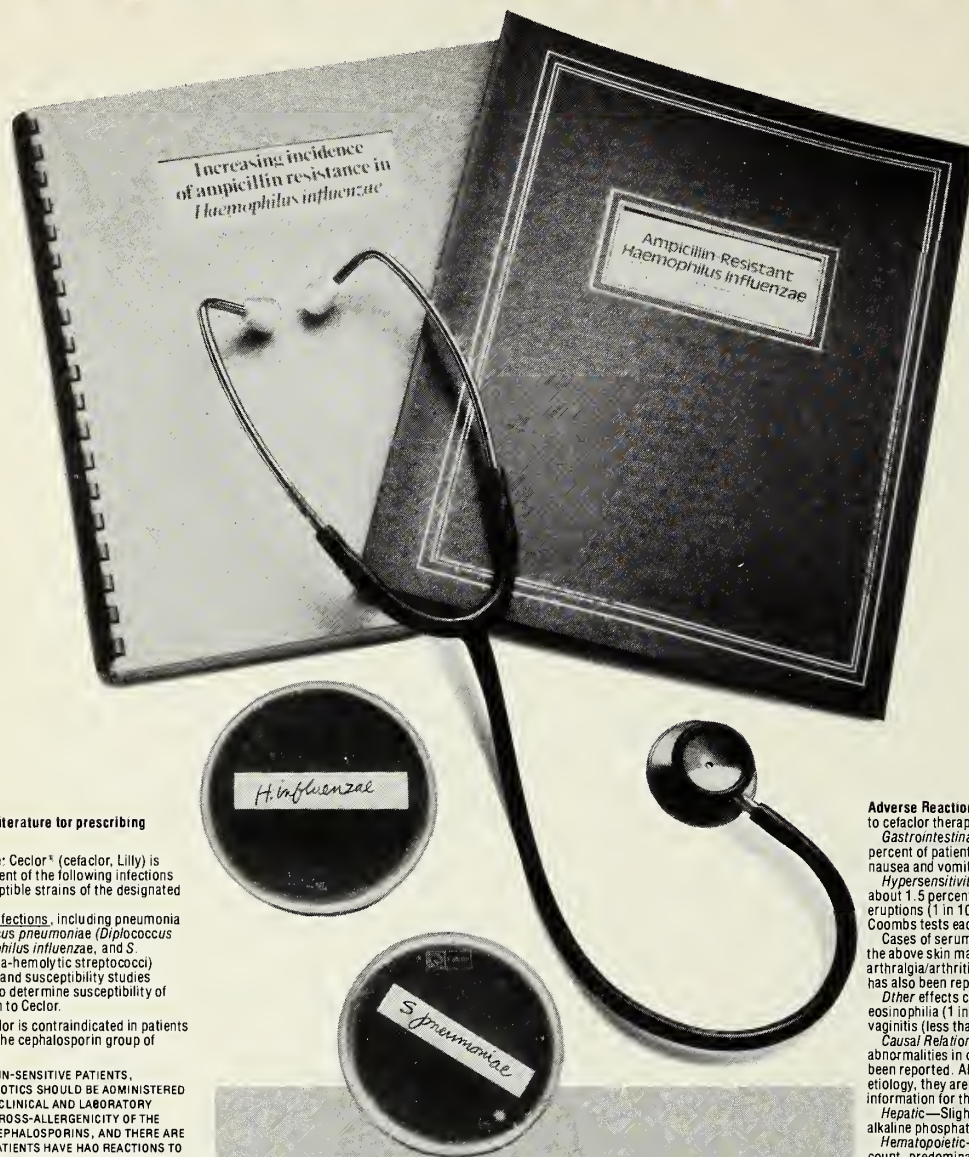
It is important for IMS member physicians to know the long-standing Iowa Medical Political Action Committee (IMPAC) and the American Political Action Committee (AMPAC) follow all legal stipulations in directing their resources to candidate support. And it is more important for IMPAC contributors to know that better than 95% of what they give by personal check goes directly to support candidates. We should be mindful that personal contributions (not a professional corporation check) must be given if the donation is to be used for candidate support.

Our objective for this decade should be to foster the relationship between a person's vote and the behavior of government. PACs are an effective and viable way of doing this. We need to encourage their efforts.

John H. Kelley, M.D.

On behalf of the officers of the Iowa Medical Society, may I extend warm wishes for a pleasant holiday season.

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Contraindication: Cefclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS, AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS TO BOTH DRUG CLASSES (INCLUDING ANAPHYLAXIS AFTER PARENTERAL USE).

Antibiotics, including Cefclor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs.

Precautions: If an allergic reaction to cefclor occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e.g., pressor amines, antihistamines, or corticosteroids.

Prolonged use of cefclor may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs test may be due to the drug.

Cefclor should be administered with caution in the presence of markedly impaired renal function. Under such a condition, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended.

As a result of administration of Cefclor, a false-positive reaction for glucose in the urine may occur. This has been observed with Benedict's and Fehling's solutions and also with Clinistest® tablets but not with Tes-Tape® (Glucose Enzymatic Test Strip, USP, Lilly).

Usage in Pregnancy: Although no teratogenic or antifertility effects were seen in reproduction studies in mice and rats receiving up to 12 times the maximum human dose or in ferrets given three times the maximum human dose, the safety of this drug for use in human pregnancy has not been established. The benefits of the drug in pregnant women should be weighed against a possible risk to the fetus.

Usage in Infancy: Safety of this product for use in infants less than one month of age has not been established.

Some ampicillin-resistant strains of *Haemophilus influenzae*—a recognized complication of bacterial bronchitis*—are sensitive to treatment with Cefclor.^{1,6}

In clinical trials, patients with bacterial bronchitis due to susceptible strains of *Streptococcus pneumoniae*, *H. influenzae*, *S. pyogenes* (group A beta-hemolytic streptococci), or multiple organisms achieved a satisfactory clinical response with Cefclor.⁷

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Adverse Reactions: Adverse effects considered related to cefclor therapy are uncommon and are listed below: Gastrointestinal symptoms occur in about 2.5 percent of patients and include diarrhea (1 in 70) and nausea and vomiting (1 in 90).

Hypersensitivity reactions have been reported in about 1.5 percent of patients and include morbilliform eruptions (1 in 100). Pruritus, urticaria, and positive Coombs tests each occur in less than 1 in 200 patients.

Cases of serum-sickness-like reactions, including the above skin manifestations, fever, and arthralgia/arthritis, have been reported. Anaphylaxis has also been reported.

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients).

Causal Relationship Uncertain: Transitory abnormalities in clinical laboratory test results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician.

Hepatic: Slight elevations in SGOT, SGPT, or alkaline phosphatase values (1 in 40).

Hematopoietic: Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40).

Renal: Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200).

[1030608]

*Many authorities attribute acute infectious exacerbation of chronic bronchitis to either *S. pneumoniae* or *H. influenzae*.

Note: Cefclor* (cefclor) is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

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Additional information available to
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100061

THINGS YOU SHOULD KNOW

MEDICAID TASK FORCE

As this is prepared, two sessions of a new Iowa Medicaid Task Force have been held. This body has been constituted by the Department of Social Services to find ways of making fewer Title XIX dollars cover the needs as effectively as possible. The IMS is cautioning against any further reduction in Medicaid fees, which are already considerably below usual charges. Society EVP Eldon Huston is a member of the task force.

IOWA NONEQUIVALENT DRUG LIST

67 drug products are contained on an Iowa Nonequivalent Drug List mailed in late October to physicians and other health care providers by the State Board of Pharmaceutical Examiners. This distribution complies with the Iowa Code which states the BPE "shall cause to be issued a list of those drugs or drug products which have been demonstrated as being nonequivalent and are not interchangeable as determined by the FDA." Copies of the list are available from IMS headquarters.

1982 DUES

1982 dues notices were mailed to member physicians in mid-November. Dues remain at the \$275 level set by the 1977 IMS House of Delegates. The IMS continues to provide administrative dues billing services to all but 5 county medical societies. 1981 membership reached 3,060 in October to surpass the previous year.

TRY OUR PRINTING SERVICE

5,000 Rx forms (50 pads of 100 each) for \$50! The new IMS printing service is making this special offer to interested member physicians. Recent acquisition of a new offset press allows the Society to accept a limited amount of additional printing. Stationery, envelopes, forms, statements, etc., can be handled. Contact IMS headquarters.

HMO/IPA FOR WATERLOO

Members of the Waterloo medical community will team with Deere & Company to offer care to Deere employees via a new health maintenance organization/individual practice association. Announcement of the formation of the IPA came in October with a further indication that the program will seek to be operative 1/1/82. The Waterloo plan will be similar to one operating in Davenport. Gilbert Clark, M.D., is the newly elected IPA president.

STATEWIDE HEALTH COVERAGE

The IMS Statewide Physicians Health Program offered through Blue Cross/Blue Shield will see a 14% rate increase as of 1/1/82. The Society's Committee on Member Services reviewed 1980/81 program experience at an October 22 meeting and acknowledged the need for the higher rate. The new rates will range from \$57.59 to \$146.88 for family coverage depending on the option chosen and from \$36.46 to \$55.68 for single coverage. There are 1,542 active contracts under the program. The expanded coverage was introduced in 1981 and offers three options as to deductibles and co-insurance. The IMS committee is asking enrollment in the program remain open throughout 1982.

NAMED TO STATE POST

IMS President-elect Hormoz Rassekh, M.D., Council Bluffs, and Vera French, M.D., Bettendorf, have been named by Governor Ray to the new State Mental Health and Mental Retardation Commission.

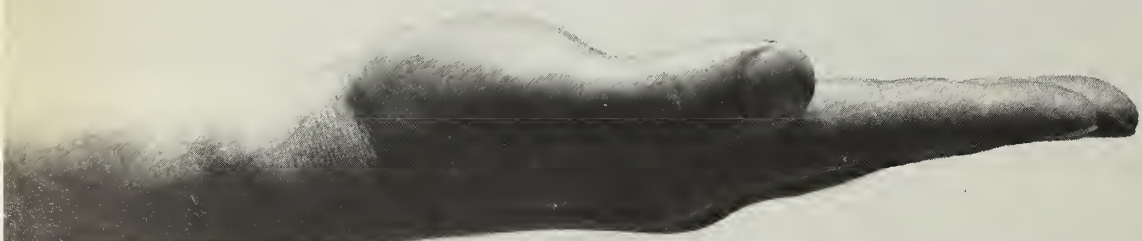
VINTON PICKED AS RURAL SITE

The Benton county community of Vinton became a new outreach training site for the Black Hawk Area Family Practice Residency program beginning in November. Residents from the Waterloo family practice program will spend two months in Vinton in training with three community physicians. This training expansion is part of the U. of I. College of Medicine Rural Medical Services Development Program.

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QUESTIONS - ANSWERS

SAYEED HUSSAIN, M.D.
Des Moines, Iowa

NEW CONVALESCENT HOME FOR CHILDREN

Dr. Hussain is medical director at the new 4.8 million dollar Convalescent Home for Children located in Johnston, Iowa. He comments here on this facility which opened this year. Dr. Hussain also practices pediatrics in Des Moines.

The Iowa Convalescent Home for Children is located in a new facility in Johnston. Tell us a little about the new structure.

Our new Convalescent Home, located in Johnston, Iowa, is a 4.8 million dollar home providing Skilled and ICF/MR care for 60 children. Each child lives in a colorful private or semi-private room. The rooms are designed and decorated to promote a warm, home-like atmosphere. This home is the largest of its kind known in the nation. It is open to children of all races, colors, and creeds.

Are there services you can now provide that were not available at the old location?

The trained professional staff at the Convalescent Home develop and carefully design an individual program of services for each child depending on individual needs. The services available include: medical and nursing services, dental services, physical therapy, aquatic therapy, educational services, psychology services, occupational therapy, parent counseling, speech and audiology services,

recreation therapy, beautician services, social services and therapeutic carpentry.

How many children will the new facility accommodate? What are the plans for expansion?

Our current facility accommodates 60 children. Plans for future expansion include adding two 20-bed units to the existing structure. We also hope to build adjacent cottages.

Is the facility available only to residents of Des Moines and the surrounding area?

Residents of Des Moines and Polk County are served first if at all possible. We also take into account the medical needs of the applicant child, with the most serious cases being considered first. We do have children living in our Home from all over the State of Iowa.

Can Iowa physicians refer patients to the facility?

Iowa physicians are welcome to refer children to the facility. This can be started by calling Convalescent Home social workers at 515/270-2205. It is important that written evaluations and medical information be submitted on any child referred to the Home. This material will be reviewed by the admissions committee.

Are contributions still needed to support the Convalescent Home?

Yes. In the spring of 1981, the Convalescent Home for Children Foundation was incorporated as a separate non-profit public corporation for the purpose of granting and rendering financial assistance to the Convalescent Home for Children, and to other non-profit and charitable corporations that care for physically handicapped and developmentally delayed children.

The funding of the Convalescent Home for Children Foundation comes from tax-exempt contribution(s) which may be in the form of cash, checks, gifts of stock, a beneficiary in a life insurance policy, or through a bequest in a will. Should you wish to financially assist the efforts of the Convalescent Home for Children Foundation, please write or telephone: The Convalescent Home for Children Foundation, P.O. Box 186, Johnston, Iowa 50131, 1-(515)-270-2191.

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OUR MAN ON EDUCATION

RICHARD M. CAPLAN, M.D.

EDUCATION TO SAVE LIVES IN A NUCLEAR WAR?

THE PROSPECT FOR NUCLEAR WAR seems to be making grim headway, doesn't it? At least the discussion of it suggests as much, for I've been seeing more published about it in newspapers, magazines, and now even in medical journals.

How ironic that this gloomy vista of incredible numbers of human fatalities arises coincident with what will surely stand as one of medical science's brightest accomplishments: the total eradication of smallpox from the world! I contend we each, right at home, contributed slightly to that splendid victory whenever we vaccinated a patient with the vaccinia virus. That tiny increment toward worldwide herd immunity, repeated millions of times and coupled with immense cleverness, vigorous case finding effort, hard work and luck, finally won the battle without our personally travelling to Bangladesh or Somalia. Is there a way we might make a similar small benefaction in the struggle to prevent a nuclear cataclysm?

Most physicians in America, through some combination of national customs, habits and medical education, seem to focus on the care of the individual ill patient who presents to us. Concern for the collective health and the problem of illness affecting entire populations has generally been shunted to some small cadre of physicians who, to our immense good fortune,

are interested in the public health and whose labors ultimately make our nation and world a vastly more healthy and safe place. On the other hand, do you personally do what you could, for example, through education of patients, either singly or in groups, to urge the use of seat belts and the moderate use of alcohol as ways of reducing our immense highway butchery? Do you drink in moderation and faithfully use your own seat belt, or does it suffice that you be exceedingly well-skilled in maintaining cardiopulmonary function of the patient whose auto-wreck-mangled flesh you reposition and stitch? Would you take action if multiple cases of Legionnaires' Disease were appearing in your community?

The AMA's Board of Trustees' Report P (A-81) a few months ago recommended that the AMA "develop a program for voluntary physician education . . . to deal with medical and health problems *in the event of a nuclear attack*" and that it "support civil defense efforts designed to reduce death and injury and to educate the public to *reduce exposure to weapon effects* (emphasis added)." How sad that they did not favor in their recommendations that physicians try to *prevent catastrophe*. But fortunately, the House of Delegates obliged a rewriting of the final report to say, "That the AMA recognizes the catastrophic dangers to all life in the event of nuclear war and supports efforts for the prevention of such a nuclear holocaust."

To respond with total inactivity in the face of great danger is a characteristic of opossums. Obviously such behavior is not their monopoly. What action can you and I take that might be analogous to the part we played in the smallpox saga by performing vaccination in our offices and communities? It seems to me we must acquaint ourselves well with the nature and magnitude of the hazard. That will prepare us to teach our patients and fellow citizens and contribute to the sensitization of public opinion. This immense task of preventive medicine can't be done by adding a purifying or tranquillizing chemical to the water supply, at least not yet. We must depend on an enlightened public to make its voice heard, and we can help produce that enlightenment. A place to start would be to read two articles: *The Nuclear Arms Race and the Physician*, page 726, March 19, 1981 issue of the NEW ENGLAND JOURNAL OF MEDICINE, and *Preventing the Last* (Please turn to page 535)

Dr. Caplan is Associate Dean for Continuing Medical Education at The University of Iowa College of Medicine.

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To learn more about IRBS, we encourage you or your staff to attend the training workshops scheduled in your area. Other features of the new data processing system will be explained in future mailings of ON RECORD.



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Compensable Back Injuries And Their Management

THOMAS R. LEHMANN, M.D.

Iowa City, Iowa

THE PATIENT with a compensable low back injury is afraid. He has been hurt and he perceives he is not being told the truth about the condition. The patient has questions which concern him: *What if I am unable to return to work? What if I return and am unable to perform adequately? Does a foreman, supervisor, personnel officer, or plant physician have a grudge against me?* The patient may have short term financial security but faces the uncertainty of not knowing about the long term. To maintain his security the patient often focuses main attention on proving his back hurts. Without being consciously aware of it he decides to be disabled and to prove it. The problem is compounded because many of these patients have a minimum of education and a poor understanding of the Worker's Compensation system. They can be advised by well-meaning friends or union representatives about their "rights" but still left unaware of the concept of secondary gain and work disincentives. The lines of battle are clearly drawn. The company doctor or its representative cannot be trusted. The patient turns to his family physician with whom he has developed trust.

The author is an assistant professor in the Department of Orthopaedic Surgery at the University of Iowa College of Medicine.

Aiding the individual with a work related back injury is a challenge for Iowa physicians. The doctor must advise the patient medically, and he must also understand and explain the legal implications of disability and impairment.

The family physician must know how to advise the patient medically, and he must explain the legal implications of his medical judgment. Making the necessary decisions is not difficult once a physician becomes familiar with the problem. The following is presented to serve as a model for the Iowa physician.

ACUTE BACK PAIN

Acute low back pain conditions are most difficult to provide an objective anatomical diagnosis. The one exception is in the patient with a herniated nucleus pulposus. This condition covers less than 10% of all acute low back pain.¹ Therefore, most acute soft tissue back injuries must be treated as other idiopathic conditions, according to the natural history. Regardless of treatment, 85 to 90% of patients will be improved by 2 to 3 months.² The only prospective randomized treatment shown to be effective is absolute bed rest.³ This study also demonstrated that analgesic medications reduce pain but do not alter the recovery time. By 14 days after onset most patients can be safely started on isometric abdominal exercises. Although other more aggressive exercise programs may be effective for certain patients they may also provoke more pain.⁴

Start the patient on one exercise only, the

THE SCANLON MEDICAL FOUNDATION/IOWA MEDICAL SOCIETY HAS DESIGNATED THIS ARTICLE AS THE HENRY ALBERT SCIENTIFIC PRESENTATION FOR THE MONTH OF DECEMBER 1981

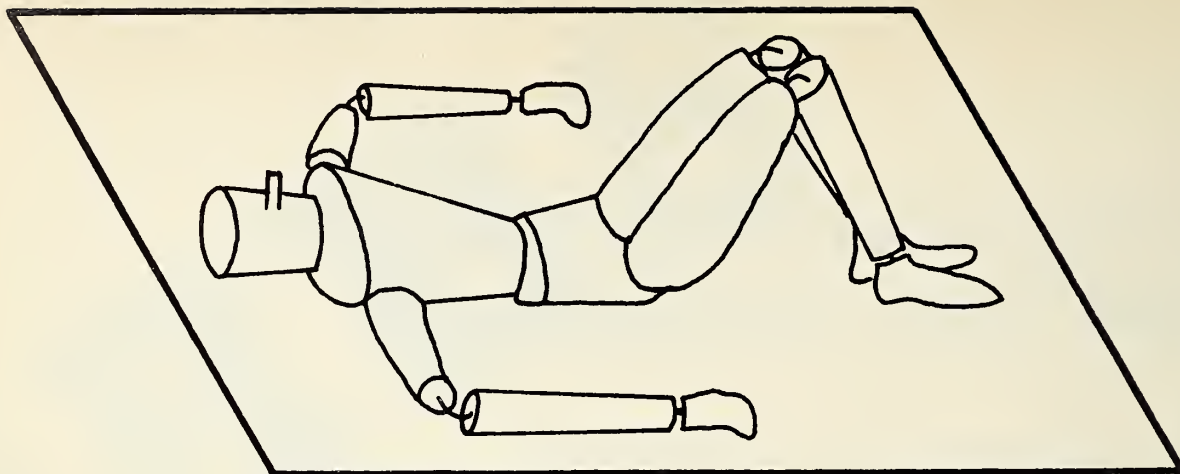


Figure 1. The Pelvic Tilt is accomplished by tightening the muscles of the lower abdomen and buttocks at the same time so as to flatten the back against the floor.

pelvic tilt (Figure 1). When the patient has mastered the exercise in the supine position he should start the same exercise against the wall with his heels several inches away. The patient should hold the pelvic tilt during all activities of the day. The following concept should be stressed: What one does with his back all day long is more important than the 15 minutes of exercise. The idea of actively preventing pain by posturing is emphasized over the masking the pain with pills.

The patient should know first (and in language he or she can understand) about the nonspecific and idiopathic nature of the condition as well as its favorable natural history. The patient is closely observed for any concern which he/she may have. The patient usually has difficulty identifying and expressing his/her fears. The physician's role is to reassure the patient. The patient's attention needs to be on active participation in the recovery process rather than proving his/her disability.

CHRONIC BACK PAIN

If the patient is one of the 10 to 15% who are not improved and back at work in 3 months then more advanced knowledge and expertise are required. A decision must be made at this point to use a surgical treatment model or a rehabilitation model. The surgical model implies that an "expert" can find the anatomical cause, treat it, and resolve the condition. The rehabilitation model implies that the patient

has an impairment or handicap which cannot be "fixed." The patient must focus on accepting the handicap and returning to function despite the handicap.

Because the results of rehabilitation are so poor when disability is prolonged more than 6 to 12 months, it is essential to decide about a surgical or rehabilitation model as soon as possible after the 3 month interval.⁵ Rehabilitation can be achieved through an inpatient rehabilitation or spine pain program. Alternatively, a knowledgeable physician may monitor the patient who uses the facilities of a YMCA, health club or dance studio. The decision about surgery versus rehabilitation should be firmly stated once it is made. The patient must accept the handicap. He/she cannot be thinking: If rehabilitation doesn't work, there is always surgery. If a second opinion is desired, the patient should be encouraged to obtain it. He should be informed, however, that once obtained there should be no procrastination about rehabilitation if all opinions indicate no surgery.

MEDICAL JUDGEMENT AFFECTING THE LEGAL ASPECTS

Advising the patient as to the legal implications of the medical judgment can be made easy for the physician and therapeutic for the patient. The physician often makes the task difficult by avoiding necessary decisions. Prolonging the task increases the difficulty. There

is no need to agonize over the problems and decisions. The following decisions must be made:

- (1) If the condition is compensable,
- (2) When the healing period is over, and
- (3) If and how much permanent impairment exists.

If the condition began or was aggravated by work it is compensable. This decision should be clear when the patient gives the history. The history should include the past history of back conditions, injuries or unusual incidents at work, onset of symptoms, job description and first medical documentation of the problem.

When the physician can see further medical improvement is unlikely then he must state that the healing period is over. It may be to the patient's long term benefit to establish the end of the healing period as early as possible. Although the total amount of dollar compensation received increases as the length of the healing period increases, prolonged disability may ultimately decrease the patient's chances of returning to gainful employment, and therefore his long-term income. If the disability lasts longer than a year, there is a good chance the patient will never return to work. If the physician discusses all these aspects with the patient early, it will make it easier to determine the end of the healing period at the appropriate time. Also, the patient should be encouraged to work hard for his recovery while he is in the healing period. The patient must understand but not be intimidated by the fact that a failure to show improvement forces the physician to terminate the healing period. Care should be taken with these discussions. The patient's trust in the physician as his advocate must be preserved.

The patient should know terminating the healing period also terminates temporary total disability payments. This termination then requires the physician to make a final decision regarding permanent, partial impairment.

The physician determines only the impairment not the industrial disability. The former is an estimate of the percentage of the whole body which does not function. The latter is an estimate of how the impairment or handicap affects the patient's ability to work. Industrial disability depends on age, education, personality, previous job experience and social factors. Although it is difficult for the physician to separate out these factors when determining

the impairment, it conceptually makes the task simpler for the doctor. The tissue injury, and therefore the impairment, is established at the onset. Subsequent observations after a reasonable period of healing time allows one to estimate the degree. Once a decision has been made for rehabilitation and against surgery, medical treatment will not alter the impairment. Rehabilitation may alter the disability but not the impairment. It is, therefore, possible to state reasonably early (i.e. 3-6 months) that a permanent impairment may result so as to estimate its percentage. Reports to workers's compensation carriers should be stated carefully. Estimating a possible permanent impairment (as opposed to establishing a definite partial permanent impairment) can sometimes be misconstrued as a termination of the healing period.

A recent survey of Iowa Orthopedic Society members found the responders would wait an average of 9 months following an injury, or 10 months following back surgery, to establish the permanent impairment rating.⁶ However, earlier discussion of this aspect with the patient is preferred.

By 3 months the physician explains to the patient:

- (1) *The difference between temporary total disability and permanent partial disability.*
- (2) *The difference between permanent partial impairment and permanent, partial disability.*
- (3) *The progress of the patient determines the end of the healing period.*
- (4) *An estimate of the possible permanent partial impairment.*

The patient is informed early for several reasons. First, it establishes between physician and patient that there is a significant problem. The patient doesn't have to prove his disability to the physician. Secondly, the patient knows how much or little money he can expect as a settlement. The importance of this can best be understood with an example. Assume that the patient has a Grade I spondylolisthesis with spondylolysis at L5; the history clearly establishes an aggravating incident at work. Surgical decompression and fusion for this condition is usually successful if the impairment is severe enough to warrant surgery. The decision to operate is subjective and based on the patient's perception of pain and dysfunction.

(Please turn to page 530)

Most patients with this condition do not require surgery. If the impairment rating is established prior to surgery, secondary gain is less likely to influence the patient's decision to have an operation as well as the surgical result. An adjustment or reconsideration of the impairment rating can always be made. Early estimation of an impairment rating and open discussion with the patient allows both patient and doctor to concentrate on the decisions to be made about the patient's health.

The patient should be aware that accepting a permanent partial disability award does not necessarily mean giving up future medical benefits. Any questions that arise can usually be answered by the Industrial Commissioner's office. This agency can often facilitate communication between the patient and the worker's compensation carrier. The patient should be advised to contact the Department of Vocational Rehabilitation even if he plans to return to his original job. If it should work out that he is unable to return to that job, he will have had

the opportunity to consider other alternatives and save valuable time. Educating the patient will reduce his fears. The educational process clears the air so the physician has less anxiety about the social and legal implications of his decision. The sooner these discussions occur the earlier realistic consideration of rehabilitation concepts can develop. There is no objective scientific way to make these decisions. The physician should trust his judgments and share the decisions with the patient.

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A majority of the works summarized in the catalogue are gifts to The University of Iowa from John Martin, M.D., a neurosurgeon from Clarinda, Iowa. His profound knowledge of medical history was indispensable in the selection of works and in the preparation of annotations. The catalogue has reproductions of 97 notable illustrations from the listed books. Cost of this impressive volume is \$50. An order form is below.

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Refugee Health Screening

W. M. JAGIELLO, D.O. and

E. T. THOMAS, Ph.D.

Des Moines, Iowa

IN MEDICAL PRACTICE in the United States today, most physicians rarely encounter certain infectious and parasitic diseases. When these encounters occur, it is usually simple to obtain a medical history from the patient, order the laboratory or radiological procedures which are pertinent, and then select an appropriate therapeutic regimen.

However, the arrival of Indochinese refugees the past year or so has brought a therapeutic challenge to American physicians. This is a brief report on the management of two Cambodian families who arrived in the United States the summer of 1979.

The "Morbidity and Mortality World Report" of August 24, 1979, published by the CDC, made the following points:

1. *The majority of refugees will be free of major contagious diseases;*
2. *When an illness is present, it will likely represent a personal rather than a public health problem, and;*
3. *The main health problems will include tuberculosis and parasitic diseases.*

With these points in mind, contact was first established with the families through the American sponsor responsible for assisting the refugees in settlement. A meeting to discuss health care included the sponsor, a public health nurse and a physician. During this meeting several problems became evident:

Another brief report is presented on procedures established to take care of refugee families resettling in Iowa. The goal is one of reviewing the health status of each family member while minimizing the stress.

none of the refugees spoke English; the families involved were extended families with 10 members in one household and 4 in the other, and records from prior medical screening were not completely available. As a result of this discussion, it was decided to implement a health screening protocol with 2 goals in mind:

1. *To fully utilize paraprofessional assistance when possible, including public health nurses, interpreters and the sponsor. With appropriate instructions from a physician, the majority of diagnostic testing and treatment could be carried out in the home.*

2. *To diagnose and treat infectious and parasitic diseases when present, and to initiate basic preventive health measures such as immunization and prenatal care.*

The protocol we developed consists of 6 basic steps:

1. *Identification of acute illness.* The following symptoms indicate a need for prompt medical attention — diarrhea, fever, malaise, vomiting or abdominal pain.

2. *Screening for tuberculosis.* Skin testing will be performed on all individuals, including children and pregnant women. When indicated, further testing will be done, including chest X-rays and sputum cultures for acid fast bacilli. (Note: a BCG immunization may give a falsely positive skin test).

3. *Screening for parasites.* On 3 consecutive days stool specimens will be collected from each individual and examined for ova and parasites.

Dr. Jagiello is in family practice in Des Moines. Dr. Thomas is a microbiologist at Mercy Hospital Medical Center in Des Moines.

(Please turn to page 535)

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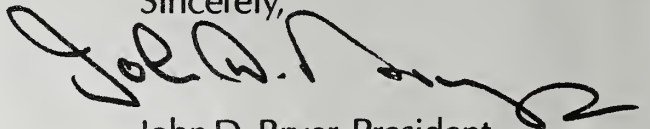
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INDICATIONS AND USAGE: Treatment of signs and symptoms of rheumatoid arthritis and osteoarthritis during acute flares and in the long-term management of these diseases. Safety and effectiveness have not been established for Functional Class IV rheumatoid arthritis.

Relief of mild to moderate pain.

CONTRAINDICATIONS: Patients hypersensitive to ibuprofen, or with the syndrome of nasal polyps, angioedema and bronchospastic reactivity to aspirin or other nonsteroidal anti-inflammatory drugs (see WARNINGS).

WARNINGS: Anaphylactoid reactions have occurred in patients hypersensitive to aspirin (see CONTRAINDICATIONS). Peptic ulceration and gastrointestinal bleeding, sometimes severe, have been reported. Peptic ulceration and gastrointestinal bleeding, sometimes severe, have been reported. Peptic ulceration, perforation, or gastrointestinal bleeding can end fatally; however, an association has not been established. Rufen should be given under close supervision to patients with a history of upper gastrointestinal tract disease, and only after consulting the ADVERSE REACTIONS.

In patients with active peptic ulcer and active rheumatoid arthritis, nonulcerogenic drugs, such as gold, should be attempted. If Rufen must be given, the patient should be under close supervision for signs of ulcer perforation or gastrointestinal bleeding.

PRECAUTIONS: Blurred and/or diminished vision, scotomata, and/or changes in color vision have been reported. If developed, discontinue Rufen and administer an ophthalmologic examination.

Fluid retention and edema have been associated with Rufen; caution should be used in patients with a history of cardiac decompensation.

Rufen can inhibit platelet aggregation and prolong bleeding time. Use with caution in patients with intrinsic coagulation defects and those taking anticoagulants.

Patients should report signs or symptoms of gastrointestinal ulceration or bleeding, blurred vision or other eye symptoms, skin rash, weight gain or edema.

To avoid exacerbation of disease or adrenal insufficiency, patients on prolonged corticosteroid therapy, this therapy should be tapered slowly when adding Rufen.

DRUG INTERACTION: Coumarin-type anticoagulants. The physician should be cautious when administering Rufen to patients on anticoagulants.

Aspirin. Concomitant use may decrease Rufen blood levels.

PREGNANCY AND NURSING MOTHERS: Rufen should not be taken during pregnancy nor by nursing mothers.

ADVERSE REACTIONS

Incidence greater than 1%

Gastrointestinal: The most frequent adverse reaction is gastrointestinal (4% to 16%). Includes nausea*, epigastric pain*, heartburn*, diarrhea, abdominal distress, nausea and vomiting, indigestion, constipation, abdominal cramps or pain, fullness of GI tract (bloating and flatulence). **Central Nervous System:** dizziness*, headache, nervousness. **Dermatologic:** rash* (including maculopapular type), pruritus. **Special Senses:** tinnitus. **Metabolic:** decreased appetite, edema, fluid retention. Fluid retention generally responds promptly to drug discontinuation (see PRECAUTIONS).

*Incidence 3% to 9%.

Incidence less than 1 in 100

Gastrointestinal: gastric or duodenal ulcer with bleeding and/or perforation, hemorrhage, melena. **Central Nervous System:** depression, insomnia. **Dermatologic:** vesiculobullous eruptions, urticaria, erythema multiforme. **Special Senses:** amblyopia (see PRECAUTIONS). **Hematologic:** leukopenia, decreased hemoglobin and hematocrit. **Cardiovascular:** congestive heart failure in patients with marginal cardiac function, elevated blood pressure.

Causal relationship unknown

Gastrointestinal: Hepatitis, jaundice, abnormal liver function. **Central Nervous System:** paresthesias, hallucinations, dream abnormalities. **Dermatologic:** alopecia, Stevens-Johnson syndrome. **Special Senses:** conjunctivitis, diplopia, optic neuritis. **Hematologic:** hemolytic anemia, thrombocytopenia, granulocytopenia bleeding episodes. **Allergic:** fever, serum sickness, lupus erythematosus syndrome. **Endocrine:** gynecostasia, hypoglycemia. **Cardiovascular:** arrhythmias (Sinus tachycardia, bradycardia, and palpitations). **Renal:** decreased creatinine clearance, polyuria, azotemia.

OVERDOSAGE: Acute overdosage, the stomach should be emptied. Rufen is acidic and excreted in the urine, alkaline diuresis may benefit.

DOSAGE AND ADMINISTRATION: Rheumatoid arthritis and osteoarthritis, including flareups of chronic disease: Suggested dosage 400 mg t.i.d. or q.i.d.

Mild to moderate pain: 400 mg every 4 to 6 hours as necessary for relief of pain. Do not exceed 2,400 mg per day.

CAUTION: Federal law prohibits dispensing without prescription.

Boots Pharmaceuticals, Inc.
Shreveport, Louisiana 71106

Traditional Health Beliefs/ Practices Of Vietnamese Refugees

TONI TRIPP-REIMER, R.N., Ph.D., and
KATHLEEN THIEMAN, R.N.

SINCE THE FIRST Vietnamese evacuees were airlifted to Guam in April 1975, nearly 200,000 Indochinese refugees have come to the United States. More than 5,000 of these refugees (1,600 from Viet Nam) currently reside in the State of Iowa.²

Many illnesses which are nearly unknown in the United States are common among Indochinese refugees. In the camps where the refugees resided prior to arriving in Iowa, most of their acute diseases and malnutrition problems were corrected. Remaining conditions usually include anemias, intestinal parasites, dermatitis, recurrent bouts of malaria, latent tuberculosis, and some leprosy.¹ In a recent Denver study, major health problems of Vietnamese refugees were tuberculosis, intestinal parasitic infections, hepatitis, and viral infections. However, 80% of the refugees interviewed waited 5 days after the presentation of symptoms to consult a physician, and nearly $\frac{3}{4}$ of these failed to return for follow-up.¹²

This reluctance to seek Western health care and the high rates of non-compliance with prescribed regimens has, in part, been attributed to cultural differences between physician and client.¹¹ Because Indochinese health care beliefs and practices differ dramatically from

Caring for Vietnamese patients is becoming more and more common among Iowa physicians. This discussion of the customs, values and health beliefs/practices may help physicians in providing treatment to these refugees.

those of American physicians, the behaviors of each group are likely to be misunderstood. In multi-ethnic health care situations, physicians and other health professionals must be sensitive to deeply held traditional ideas and customs. This paper describes customs, values and common folk medical beliefs of the Vietnamese that merit important consideration by health care professionals.

CUSTOMS

If ignored, cultural differences in customs may readily lead to misunderstandings. For example, while all cultures have age categories, methods of determining age vary widely. For most Southeast Asian children, age is calculated roughly from conception. Thus, most children are considered to be one year of age at birth, and they gain one year at every New Year or Tet. If a child were born just before Tet, he would be two years old by Indochinese counting, but less than one month old by Western counting. The implications for accurate determination of age are obvious for health and developmental assessments as well as for school placement.¹

The physician also needs to obtain information regarding his refugee patients' health care experiences in Asia. In Vietnam, hospitals were staffed only part time; the rest of the time (evenings and nights) patients were attended by their own families. Family members stayed with the patient, slept in his room, adminis-

Dr. Reimer is a nurse anthropologist and associate professor at the University of Iowa. Ms. Thieman is a graduate student whose thesis topic is Health Practices of Vietnamese Refugees in Des Moines, Iowa.

tered medication and cooked his meals beside the hospital beds.^{5, 14} On the basis of their previous experience, Indochinese currently being advised to enter a hospital may anticipate the need to bring their own kin to the hospital to feed and care for them during evenings and nights. The organization of the hospital as a 24-hour care facility must be stressed. In addition, flexible visiting schedules should be arranged with hospital staff.

The method of naming individuals also differs from the Western pattern. Family names always appear first in Vietnamese practice, which usually employs three names. The second name usually refers to the child's sex (*van* for males and *thi* for females). The given name is the final name. Formal address dictates the use of Miss, Mr. or Mrs. before the third or given name. Physicians should also be aware that secret nicknames are commonly used by the family and friends. This practice results from the belief that because the given name is equivalent to one's soul, it is unwise to use the real name as it might catch the attention of the spirits.¹³

Finally, American "standard practices" may be unfamiliar or unacceptable to the Vietnamese. For example, circumcision is not considered an acceptable practice by many Indochinese. Interviewing Vietnamese refugees, Stringfellow found that many women who delivered in American hospitals were not aware that they were consenting to such a procedure for their newborn sons.¹³ Careful explanation of such procedures merits special attention.

VALUES

In contrast to the American emphasis on individual responsibility, the *family* is the standard unit of the Vietnamese society. The individual exists only as a family member, and he is always subordinate to it.⁵

The crux of family loyalty is filial piety which commands children to honor their father and mother. It is difficult for Westerners to understand the power and importance of kinsmen to the Vietnamese. Almost invariably, someone from the family will escort the patient to the doctor's office, and someone will stay with him through his hospitalization. As Tung (1972) noted, "in most cases, the relatives more than the patients are the ones to be convinced before the patient can start or continue a therapeutic program."¹⁴

Emphasis on self-control is another traditional value of the Vietnamese, who strongly believe that it is one's duty to maintain an even temper. Emotions are generally kept to one's self, and expressions of disagreement which might irritate or offend are avoided.⁶ Hostility is generally not expressed toward persons considered superior such as parents, physicians or teachers. A smile or "yes" from a Vietnamese may not necessarily indicate compliance or agreement as much as an unwillingness to be disrespectful. Thus, an authoritarian directive approach by a physician may elicit only token verbal agreement from the Indochinese patient.

MEDICAL BELIEFS AND PRACTICES

Vietnamese often use folk treatments concurrently or prior to seeking American health care. Because Southeast Asia has been under Chinese influence for thousands of years, the Chinese medical system forms the basis for the majority of Indochinese refugee health beliefs and behaviors. Having existed over 4,000 years, this medical system is an amalgamation of sacred, secular and Western (scientific) health beliefs and practices.

Chinese medicine views the body as a system of dynamic interactions between intrinsic body parts and the extrinsic environment. Health is seen as a state of physical and spiritual harmony.

The body is made up of two dynamic opposing forces, the Yin and the Yang. Yang forces include substances categorized as hot, strong, large, male, or positive. Yin forces include substances categorized as cold, weak, small, female or negative. When the Yin and Yang are out of balance, illness results.

Conditions thought to result from excesses of the biological or psychological state of the body is a Yang state; a deficiency is a Yin state. Thus, fever is Yang and chilling is Yin; hypertension is Yang and hypotension is Yin. Treatment occurs by the principle of opposition, so that Yin illnesses are treated by Yang foods, medications and rituals; Yang illnesses are treated conversely.^{8, 15}

A balance between heat and cold is believed essential to physical well-being. Foods, medicines and procedures have hot or cold qualities that must be considered in maintaining a proper balance in diet and in treating illness. For example, acupuncture (a "cold" treatment) is

most appropriate for Yang illnesses; moxibustion (a "hot" treatment) works most effectively for Yin illnesses.³ These distinctions merit important consideration in clinical settings. In childbirth, for example, Vietnamese believe that the mother dissipates much heat from her body. To restore the balance, she is fed Yang foods to replace the heat. Yang foods generally include protein-rich, spicy or fatty foods. Yin foods include herbal teas or vegetables. Additionally, it is believed that early ambulation or showering after childbirth is dangerous because the pores are open for 30 days after delivery, making one more susceptible to cold Yin forces.

The use of medications on a continuous basis is not a usual form of Indochinese treatment; Vietnamese are more familiar with a one-time dosage such as herbal tea to cure a "hot" stomach. As a result, these clients should be given careful explanations regarding reasons for taking oral medications over several days, and need to be cautioned that no more than the prescribed dosage should be taken.

Finally, problems of misdiagnosis may occur from physicians' lack of familiarity with lay Vietnamese folk medical practices. For example, the Vietnamese lay practice of dermabrasion (Cao Gio) is a home treatment for minor ailments such as fevers, chills and headaches. In this procedure, oil is applied to the back and chest with cotton swabs. The oil is massaged into the skin until the skin is warm. Then the edge of a coin is rubbed on the skin with firm strokes to produce petechiae. This treatment has led to physicians' misdiagnoses of child battering.^{4, 16}

SUMMARY

In summary, the customs, values and health beliefs and practices of Indochinese patients merit important consideration by their physicians. Although all Vietnamese refugees were treated by Western physicians prior to entering this country, most have still retained folk medical beliefs. Knowledge and understanding of these beliefs as well as sensitivity to the refugees' lack of familiarity with the American health care system will promote more effective health care delivery.

REFERENCES

The references noted in this paper are available either from the authors or from the JOURNAL OF THE IOWA MEDICAL SOCIETY.

REFUGEE HEALTH SCREENING

(Continued from page 531)

4. *Immunizations.* Individuals under age 19 will be immunized against polio, measles, mumps, rubella, diphtheria, tetanus and pertussis. Those over age 19 will be protected against measles, rubella, diphtheria, and tetanus. (Pregnancy is a contraindication to immunization with viral vaccines.)*

5. *Screening for syphilis.* Serum will be collected on all patients.

6. *Complete medical examinations.* These will be performed by a physician, with attention to the following areas: infant nutrition, prenatal care, family planning, dental and eye examinations, with referral for appropriate specialty care when indicated.

We are presently in the process of implementing our protocol and results of morbidity and treatment have not yet been compiled.

In summary, we have attempted to develop a rational, step-by-step approach to the provision of medical care for the Indochinese to help minimize the stress of their resettlement.

* Morbidity and Mortality World Report. 28:396, 1979.

OUR MAN ON EDUCATION

(Continued from page 525)

Epidemic, page 2314, November 21, 1980 issue of JAMA. Further information can be had by contacting Linda Copeland, M.D., Iowa Physicians for Social Responsibility, 618 Walnut Street, Iowa City, Iowa 52240.

In this season when we think and speak of "Peace on Earth," will we only *hope* for a divine miracle and expect it to be bestowed on us because we are so deserving? I think to the contrary — the messianic vision of peace will occur only with immense human effort to achieve it. Through the help of nuclear bombs, failure will bring us the kind of peace that dinosaurs now enjoy. But if we can't find in ourselves the energy or invention to quell this threat, the most gigantic to human health and survival that has ever occurred, then maybe it would be well for us to join the dinosaurs. Let the marvelous process of biologic evolution see what it can achieve with the next try. We are indeed immersed in what H. G. Wells called "the race between education and catastrophe."



COMMENTING EDITORIALLY

MARION E. ALBERTS, M.D.
SCIENTIFIC EDITOR

CONVALESCENT HOME FOR CHILDREN

THE ORIGINAL Convalescent Home for Children in Des Moines was founded in 1928 by several local pediatricians, along with the philanthropic assistance of the Junior League and several prominent local citizens. The original Home was an old structure leased for one dollar a year.

In 1936 a new home was constructed and over the next 45 years more than 2,400 special children were provided with care and love. But, so many others needed assistance. More than 130 children found their way onto the waiting list for admission.

In 1979, a small group of dedicated persons set out to address this need. In 6 months time

over 2.6 million dollars were raised to build a 4.8 million dollar, 60-bed home. The new Convalescent Home for Children is situated in the Green Meadows Community in Johnston. It is the largest of its kind known in the nation. It is open to all races, creeds and colors on a first-come, first-serve needs basis, with the more serious cases receiving priority. Young babies, children and adolescents suffering from serious congenital problems are provided with an all-encompassing program of quality care. Nearly every needed service for these special children is available within the new home.

Eventually it is anticipated separate cottage units will be built to house the older patients. Other expansion plans call for school facilities on the campus of the Home, as well as eventual enlargement to serve more than the present 60 children.

It is appropriate for this new facility to be opened during the year dedicated to disabled persons. The skilled medical and nursing care to over 2,600 babies and children, representing 225 different congenital defects, is a monument to the caring devotion the people of Des Moines and Iowa have for these special children. As time passes more help will be required to fulfill the needs of more and more disabled children.

The future dreams for the Convalescent Home for Children can be met. Those dreams will provide heart warming satisfaction to the many who in their own way will contribute to the total effort. Furthermore, the fulfillment of those dreams will provide more comfort and happiness to the children who must call the Convalescent Home *their home*. — M.E.A.

A CHRISTMAS CAROL

"In the little world in which children have their existence, whomsoever brings them up, there is nothing so finely perceived and so finely felt, as injustice." — Charles Dickens: GREAT EXPECTATIONS.

A *Christmas Carol* (1843) is the best known of the Charles Dickens' books about Christmas. The plight of the Cratchett family and the illusions of Ebenezer Scrooge make this a delightful tale. They reflect the feelings Dickens

had about a number of societal problems in those tumultuous years. Dickens wrote about what he saw and what he knew. He was a self-taught and accurate reporter. He was a champion of social reform in several areas. For example, he gave his wholehearted support to establishing children's hospitals. Children aroused Dickens' compassion; this is reflected in several of his books. The suffering or early death of a child touched him deeply. His efforts helped establish funds to support England's first children's hospital (Great Ormond Street, founded in 1852). He further gave his support to the East London Hospital for Children (founded 1868), Victoria Hospital in

Chelsea (1866), and the "Evelina" in Southwark (1869).

Dickens' empathy for children drew his attention also to the problems of foundlings. He mentions, directly or indirectly, in four of his books the famous Foundlings Hospital in Coram's Fields. He was interested also in the education of children, believing there should be more emphasis on training for the crafts and "useful" knowledge. He thus hoped that crime would be reduced and the country thereby enriched. He exerted strong influences in these areas through his writings and personal appearances.

Tiny Tim is my favorite Dickens character. It was my lot several times, because of my small stature as a child, to have the role of Tiny Tim in school productions of *A Christmas Carol*. Tiny Tim illustrates the predicament of many children whose minds or bodies are burdened by disease or congenital deformity. It is our responsibility to provide the best that is possible for these children. Fortunately, our society in recent years has recognized this responsibility, and the lives of these children are now

more enriched. We can offer them more in our schools; we can provide for special training to assist in self-assurance, making for less dependency on others. In our community one such effort is in the facilities of the Convalescent Home for Children. (Please see Questions/Answers feature.)

Christmas is the season for children. Let us open our hearts and talents to them; do something to provide a better life for the child who is ill, or is in a broken home, or is the victim of parents who would abuse, or any other unhappy situation that might befall the little ones who shall succeed us in this wild but wonderful world. In the words of Tiny Tim, "God bless us every one!"; for we will be blessed by serving children, and their lives will be blessed by our efforts.

Best wishes for the Holiday Season from all of us at the IMS offices to all our wonderful readers. — M.E.A.



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DRUG THERAPY REVIEW



UNIVERSITY OF IOWA HOSPITALS AND CLINICS

REYNOLD SPECTOR, M.D., Editor

USE OF NONSTEROIDAL ANTIINFLAMMATORY DRUGS IN RHEUMATIC DISEASES

ANTIINFLAMMATORY DRUGS remain the mainstay of therapy for most rheumatic diseases. Both inflammatory arthropathies such as rheumatoid arthritis (RA) and degenerative arthropathies such as osteoarthritis (OS) can be treated with these agents. The recent availability of many newer nonsteroidal drugs has led to confusion and conflicting claims of drug efficacy. All nonsteroidal antiinflammatory drugs (NSAID) have both antiinflammatory and analgesic properties and can be expected to provide some relief of symptoms in most rheumatic conditions. The choice of which NSAID to give for an individual patient with arthritis should be guided by knowledge of the drug's action, efficacy, side effects and expense.

In general all NSAID have multiple pharmacological effects. They all inhibit prostaglandin synthesis in synovial tissue and monocytes. In addition, they stabilize lysosomal membranes, inhibit polymorphonuclear leukocyte migration and alter other mediators of inflammation such as histamine, serotonin, and kinins.¹ Pain relief may also be effected by a central analge-

sic action. Most NSAID achieve maximal therapeutic effect within a few days, and generally demonstrate maximal benefit within two weeks.² Although the structural formula is usually used to classify these drugs, a more useful approach is to group these agents based on their clinical effectiveness and toxicity.

Available NSAID can be classified into "traditional" NSAID and derivatives (aspirin, indomethacin, and phenylbutazone), "major" NSAID (naproxen, tolmetin, and fenoprofen), and "minor" NSAID (ibuprofen and ketoprofen). The "traditional" NSAID are the mainstay of antiinflammatory therapy in rheumatic diseases. Of these, aspirin remains the standard therapeutic agent against which all other NSAID are compared. No other NSAID has been consistently shown to be superior to aspirin in therapeutic response with one exception. In ankylosing spondylitis (AS), most patients prefer either indomethacin or phenylbutazone over aspirin.³ To obtain a measurable antiinflammatory effect in man, a regular dose of aspirin every four hours is needed, with the total dose being around 4 to 6 grams daily.⁴ In this dosage range, aspirin produces significant side effects of dyspepsia, GI blood loss, headaches, dizziness, tinnitus, deafness, mental changes, and altered platelet function.⁵ It is primarily the gastric complaints, tinnitus, and deafness that limit the usefulness of aspirin. Most controlled studies have demonstrated that between 25 and 50% of patients cannot tolerate aspirin in antiinflammatory doses. In one study, 10% of all hospital drug reactions were attributable to aspirin.⁶ However, many of the gastric complaints and the gastric blood loss can be significantly reduced by using enteric-coated aspirin tablets, allowing continued use of this very effective NSAID.⁷

The other "traditional" NSAID approximate aspirin in overall effectiveness when used in RA, OA or soft tissue inflammation. Moreover, they also have a patient intolerance rate of around 20 to 40%.⁵ Of these agents, phenylbutazone has been linked to the development of fatal blood dyscrasias and has been reported to be second on the list of commonly prescribed drugs causing death.⁸ For this reason, phenylbutazone should be used with great caution, if at all. Another agent that chemically belongs in the "traditional" NSAID group is sulindac. Sulindac is a derivative of indomethacin and is

This information for Iowa physicians is furnished and sponsored by the University of Iowa Hospitals and Clinics.

very similar to indomethacin in the treatment of RA and OA, but with a lower incidence of side effects causing drug withdrawal. Its long half-life also allows twice daily administration enhancing patient compliance. However, it is almost twice as expensive as indomethacin and more clinical experience will be needed to document less common and potentially serious side effects.

In summary, the "traditional" NSAID are among the most potent antiinflammatory drugs available for the treatment of rheumatic conditions. The clinical response to these drugs has been studied for many years. Aspirin is the standard of therapy for inflammatory arthritis and degenerative arthritis with indomethacin being more useful in seronegative conditions such as ankylosing spondylitis. The potential fatal complications of phenylbutazone significantly limit its usefulness in chronic inflammatory conditions. The overall efficacy of these agents is limited by their significant side effects causing drug withdrawal in about one-third of the patients. These drugs remain the most economical NSAID on the market, with a monthly patient cost of around \$1-2 for aspirin and \$14-16 for indomethacin.

The "major" NSAID (naproxen, tolmetin, and fenoprofen) are so named because they approach aspirin in antiinflammatory properties. Naproxen is the most widely used and has analgesic and antiinflammatory activity comparable to full-dose aspirin and indomethacin in RA, OA, AS, backache, soft tissue rheumatism, and in sports injuries.^{1, 2, 5} It has a long half-life and can be given twice daily. Naproxen has fewer side effects than aspirin with dyspepsia or central nervous system symptoms causing drug withdrawal in around 5 percent of patients. Fenoprofen and tolmetin are both similar to naproxen in clinical efficacy with slightly more gastric and CNS intolerance. Although the efficacy of the "major" NSAID equals aspirin, and intolerance is less than that seen with aspirin, the expense of these newer agents limits their usefulness for many patients. Monthly costs for this group of drugs are about \$20 to \$30. Therefore, they remain second-line drugs in the treatment of chronic inflammatory diseases.

The final group of drugs is classified as "minor" NSAID (ibuprofen and ketoprofen) because they have less antiinflammatory effect than aspirin. Ibuprofen was the first "new"

NSAID introduced in most countries and remains very popular. It has analgesic properties similar to aspirin but is less effective in diseases with prominent inflammation (RA, AS). These agents are tolerated well, but have no advantage over naproxen in population studies. Monthly costs are about \$18 to \$25.

There are other NSAID reported in the literature, some of which are available for clinical use. Most are propionic acid derivatives similar to ibuprofen and naproxen. To date there is no evidence that any of these agents are significantly more effective than the drugs mentioned above.

In developing a rational approach to the use of NSAID in rheumatic diseases, several principles must be understood. Most studies of NSAID activity have taken the mean clinical response of a group of patients as the indication of drug efficacy. The use of mean responses in a population of patients can obscure an important phenomenon: individual variation in response to a given NSAID is often greater than the variation of the mean response to two different NSAID. This individual variability has been demonstrated in all drugs studied.^{2,9} Complicating a straightforward analysis of individual variation in response to NSAID is the waxing and waning nature of the rheumatic disease processes. Substantial interindividual variability is also seen with drug side effects. Therefore, a small group of patients will show a striking preference for one drug over another drug. This means that the availability of several NSAID is an advantage for the patient. A second concept already mentioned is that most NSAID take only a few days to achieve maximal response if adequate doses are given and a two-week trial is generally adequate to judge clinical response. This means that the patient must be informed that a trial of several different NSAID may be needed before adequate symptomatic relief can be found.

RECOMMENDED APPROACH TO THE USE OF NSAID IN RHEUMATIC DISEASES

1. Instruct the patient in the principles of NSAID use. Inform him that certain drugs may work while others may not, and that this response cannot be predicted for each individual.

2. With most chronic inflammatory diseases,

(Please turn to page 542)

STATE DEPARTMENT/ PUBLIC HEALTH

IOWA NEONATAL SCREENING: A PROGRESS REPORT

THE IOWA NEONATAL METABOLIC SCREENING Program became a full-scale, statewide screening program January 1, 1981. The program seeks the earliest possible identification of infants with generally asymptomatic inborn errors of metabolism. Four diseases have been identified for screening. All 4 are treatable disorders. If untreated they have in common an outcome of mental retardation, illness and death. The 4 diseases are: phenylketonuria (pku), hypothyroidism, galactosemia and branched chain ketoacidemia (maple syrup urine disease).

For approximately 3 years the Birth Defects Institute of the Iowa State Department of Health, through its Subcommittee on Genetic and Metabolic Screening, has actively pursued the establishment of a program to screen for genetic and metabolic disorders in Iowa. A contract for the development of a central laboratory facility was developed and was offered under policies of the Iowa State Department of Health. The University Hygienic Laboratory and a consortium of private laboratories prepared competitive proposals which were considered by the central screening authority. Ultimately the University Hygienic Laboratory was awarded the contract as the central screening laboratory. At this point in time 21 private laboratories are also participating in the program.

This information on public health matters is furnished and sponsored by the Iowa State Department of Health.

Educational services continue to be an integral part of the program. The objective here is to inform the people of Iowa of the opportunities available for genetic and metabolic screening. A pamphlet describing the program has been developed and is currently being distributed to physicians, clinics and hospitals which treat or care for patients who would need the information.

In November 1980, the Subcommittee on Screening of the Birth Defects Institute developed guidelines for the program. The document containing these guidelines reflects the suggestions of the Birth Defects Institute to the Board of Health and establishes the standards and accepted norms for the "treatment, prevention and cure" of specific genetic and metabolic disorders.

Consultation services are available to the attending physician via the Metabolic and Biochemical Disorder Clinic of the Department of Pediatrics, University of Iowa Hospitals. These services include referral, diagnosis and management assistance. The consultant services will be an adjunct to the primary care the child receives in his home community.

For more information about the Iowa newborn screening program contact: Roger Chapman, Administrator, Birth Defects Institute, Iowa State Department of Health, Lucas State Office Bldg., Des Moines, Iowa 50319.

Data collection and analysis activities have been established to allow assurance of appropriate patient management. Monthly reports are submitted by the independent laboratories to the Iowa State Department of Health through the central screening laboratory where they are evaluated for incidence of confirmed or presumptive reports.

In August 1981, a survey of Iowa hospitals engaged in newborn screening activity was completed. The objective of the survey was to gain an understanding of the screening activity throughout the state. One-hundred and twenty-six hospitals offering obstetrical service participated in the survey. The results of the survey are contained in Table I.

An extrapolation of the 1980 birth data indicates that approximately 56% of the live births

TABLE I
HOSPITAL SURVEY
NEWBORN SCREENING ACTIVITY

			Number of Hospitals	Number of Infants
Phenylketanuria only			1	45
Phenylketanuria and hypothyroidism			26	16,237
Phenylketanuria, hypa- thyroidism, galactasemia and maple syrup urine disease				
Newborn screening program	91	26,451		
Other laboratories	8	4,380	99	30,831
Total live births				47,113

in Iowa were being screened via the Newborn Screening Program at the time of the survey.

From 1 January, 1981 through 30 September, 1981, a total of 21,944 specimens were screened at the University Hygienic Laboratory for all 4 diseases. Of these specimens, 4,081 (18.6%) were marked "repeat." Thus, 81.4% of the specimens screened represented initial screening samples. The University Hygienic Laboratory has screened 17,863 newborns during the first 9 months of 1981. It has been estimated that 34,665 infants were born during the first 9 months of 1981. The University Hygienic Laboratory screened 52% of this total. However, the lower levels of screening activity in the early months of the program biases the results toward a lower than actual figure of current success. At the current rate of specimen receipt, 135 per working day with 19% repeats, approximately 63 percent of the total newborns are being screened in the program.

TABLE II
SCREENING CONDUCTED AT THE CENTRAL SCREENING
LABORATORY CUMULATIVE REPORT THROUGH SEPTEMBER 30, 1981

Disease	Presumptive Positive	Confirmed Positive	Apparent Ratio Positive/Tested
Hypothyroidism	35	2	1/9,000 ²
Phenylketanuria	22	1 ³	1/18,000
Galactasemia	17	1 ¹	1/18,000
Branched chain ketoacidemia (MSUD)	0	0	—
Total	74	4 ^{1, 3}	—

¹ Plus 1 Duarte variant of galactasemia and one under evaluation.

² Insufficient feedback on confirmatory testing results.

³ Plus 1 hyperphenylalaninemia (mild variant of pku).

Since the implementation of the state-wide program a total of 74 presumptive positives have been identified by the University Hygienic Laboratory. The results of the screening conducted at the central screening laboratory are contained in Table II.

From national figures on incidence of these diseases the numbers would statistically be predicted to be 2 cases of phenylketonuria, less than one of galactosemia, and 4 cases of hypothyroidism. However, when working with such low incidence rates considerable variations in the frequency of the occurrence may be measured. The results of the monthly reports received from the independent laboratories are included in Table III.

TABLE III
RESULTS REPORTED BY INDEPENDENT LABORATORIES
CUMULATIVE REPORT THROUGH 31 AUGUST, 1981

Disease	Presumptive Positive ¹	Confirmed Positive ²
Hypothyroidism	39	1
Phenylketanuria	10	—
Galactasemia	2	—
Branched chain ketoacidemia (MSUD)	0	—

¹ Not all laboratories are actively reporting.

² Of those reported, the outcome is unknown in most.

The reporting system has not been well received by the independent laboratories and compliance is poor. It is difficult to tell for certain what laboratories participate and to what extent they participate.

Initial funding for the program was obtained from the federal government under a grant entitled "Iowa Birth Defects Metabolic and Genetic Screening Laboratory." In January 1982, a fee for service mechanism will be initiated to support the program.

From the data compiled at this point in time there is considerable reason for optimism in that the first 9 months of the screening program have far exceeded the expectations projected for the initial phase.

For more information about the Iowa Newborn Screening Program contact: Roger Chapman, Administrator, Birth Defects Institute, Iowa State Department of Health, Lucas State Office Building, Des Moines, Iowa 50319. Telephone: 515/281-6646.

October 1981 Morbidity Report

Disease	Oct. 1981 Total	1981 to Date	1980 to Date	Most Oct. Cases Reported From These Counties
Amebiasis	5	18	9	Black Hawk, Carroll, Dubuque
Brucellosis	3	4	6	Tama
Chickenpox	213	7245	7612	Dubuque, Black Hawk, Linn
Cytomegalovirus	4	27	22	Johnson, Polk, Story
Eaton's Agent infection	8	32	16	Linn, Dubuque, Grundy
Encephalitis, viral	7	25	29	Allamakee, Janes, Winneshiek
Erythema infectiosum	9	1162	405	Humboldt, Marion, Mitchell
Gastroenteritis (GIV)	1402	14252	15447	Linn, Polk, Pottawattomie
Giardiasis	23	110	32	Polk, Floyd, Monona
Hepatitis, A	19	193	153	Mills, Scott, Dallas
Hepatitis, B type unspecified	13	81	84	Linn, Polk
Herpes Simplex	5	51	62	Johnson, Polk, Webster
Herpes Zoster	21	209	95	Johnson, Des Moines
Histoplasmosis	2	7	1	Johnson
	3	12	22	Dubuque, Polk, Pottawattomie
Infectious mononucleosis	27	238	282	Black Hawk, Linn, Polk
Influenza, lab confirmed	0	191	110	
Influenza-like illness (URI)	4658	55065	54651	Linn, Polk, Johnson
Meningitis				
aseptic	12	70	56	Dubuque, Polk, Benton
bacterial	13	107	107	Black Hawk, Dubuque, Polk
meningococcal	5	25	11	Crowford, Jackson, Johnson
Mumps	17	63	51	Linn, Black Hawk, Des Moines
Pertussis	1	6	2	Franklin
Robies in animals	60	778	407	Kossuth, Lee, Tama
Rheumatic fever	1	8	0	Lee
Rubella (German measles)	0	4	9	
Measles	0	1	20	
Salmonellosis	35	228	144	Polk, Waadbury, Clayton
Shigellosis	6	32	51	Waadbury, Linn
Tuberculosis				
total ill	0	71	76	
bact. pos.	0	45	56	
Venereal diseases:				
Gonorrhea	573	4397	4214	Polk, Black Hawk, Waadbury
Syphilis	5	24	23	Polk, Pottawattomie, Story

Laboratory Virus Diagnosis Without Specified Clinical Syndrome: Adenovirus — 1, Cerra Garda, 1, Davis, 1, Jefferson; Guillian-Borre — 1, Green, 2, Pottawattomie, 1, Harrison; Legionnaire's Disease — 1, Clinton, 1, Davis, 1, Johnson; Scarlet Fever — 2, Des Moines, 3, Floyd, 1, Linn, 1, Poweshiek; Ascariasis — 1, Black Hawk, 1, Calhoun, 1, Monroe, 1, Polk, Alta; Caxsockie — 1, Allamakee, 2, Polk; Compylabacter — 4, Blackhawk, 1, Boone, 1, Buchanan, 1, Dallas, 1, Lee, 2, Marshall, 6, Polk, 1, Tama, 1, Warren, 1, Washington, 1, Webster; Toxic Shock Syndrome — 1, Audubon, 1, Hordin, 1, Johnson, 2, Tama, 1, Waadbury.

DRUG THERAPY REVIEW

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start with aspirin. The usual starting dosage is 2.4 grams daily in four divided doses. This is increased at 3- to 5-day intervals to 4.8 grams daily. Response is evaluated after two weeks, and if inadequate the dose can be increased to 6 grams daily if tolerated.

3. In ankylosing spondylitis, indomethacin is a reasonable first-line drug.

4. If intolerance to aspirin develops, the dosage should be reduced (central nervous system toxicity, tinnitus, deafness) or an enteric-coated preparation used (gastrointestinal toxicity).

5. If intolerance develops or the clinical response to aspirin is inadequate, change to one of the "traditional" or "major" NSAID. It is reasonable to determine drug compliance by obtaining serum salicylate levels prior to deciding that the patient is not responsive to aspirin. The therapeutic level of salicylate in plasma is generally 15-25 mg %.

6. If the second drug is inadequate, change to a third and a fourth NSAID if needed. A two-week trial of each agent is adequate to determine clinical response.

7. If intolerance to any of the NSAID develops, change to another agent and follow clinical response.

8. In chronic inflammatory conditions, the least expensive agents are preferable ("traditional" NSAID). — *Lynell W. Klassen, M.D., Assistant Professor of Medicine, University of Iowa Hospitals and Clinics*

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ABOUT IOWA PHYSICIANS

The following U. of I. College of Medicine faculty presented papers at the fall scientific meeting of the American Academy of Facial Plastic and Reconstructive Surgery — Drs. William R. Panje, Janusz Bardach, Robert M. Bumsted, Richard L. Anderson, John V. Linberg and Ruben Barreras. Dr. Panje presented a paper entitled, "Inside-Outside Techniques for Immediate Reconstruction of Thru and Thru Facial and Neck Defects." Dr. Bardach discussed "Partial and Total Nasal Reconstruction," Drs. Bumsted, Anderson, Linberg and Barreras presented a paper on "External Dacryocystorhinostomy; A Prospective Study Comparing the Size of a Surgically Created Ostium to the Size of the Healed Ostium." . . . Dr. S. Donald Zaentz, Ames, was guest speaker at recent meeting of the Ames Ostomy Group. Dr. Zaentz spoke on "New Frontiers in Cancer Treatment." . . . Dr. Lester E. Larson, Decorah physician for 51 years, retired in September. Dr. Larson received the M.D. degree at the University of Minnesota Medical School and interned at Minneapolis General Hospital. He began his practice in Decorah in 1930. Dr. Larson is a life member of the Iowa Medical Society.

DEATHS

Dr. Sidney E. Ziffren, 69, head of the Department of Surgery at the U. of I. College of Medicine, died October 1 in Iowa City. Dr. Ziffren received the M.D. degree at the University of Illinois School of Medicine; interned and served his surgery residency and a year of training in pathology at University Hospitals in Iowa City. A U. of I. faculty member since 1947, Dr. Ziffren was named full professor in 1953 and head of the Department of Surgery in 1972.

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WHEN YOU ARE serving half the state's population you've got a lot of folks under your wing, and regardless of what service you perform, you naturally want to do your best.

That's true whether you're Northwestern Bell, HyVee, Blue Cross/Blue Shield or whatever. We're talking about Blue Cross/Blue Shield here.

At the first of the year, in quest of the proverbial *better mousetrap*, Blue Cross/Blue Shield launches its Iowa Regular Business System (IRBS). This new data processing program arrives with high expectations and after extensive planning.

The challenge to IRBS is an imposing one. We say this because the Blues have a book of business that amasses over 7 million claims annually and pays in excess of \$750 million in benefits. These figures embody both private business — Blue Cross of Iowa, Blue Shield of Iowa, Major Medical, Delta Dental and the Iowa Pharmacy Service Corporation — as well as the governmental Medicare A and B. The now arriving IRBS is aimed only at the private business; Medicare has previously had a computerized facelifting.

To achieve success with the new IRBS, the Blues are betting on the know-how, professionalism and integrity of EDSF — that's Electronic Data Systems Federal. EDSF is already contracting with the Blues for Medicare, and now its nationally-regarded expertise is being applied as well to the private business portfolio.

Veteran observers may recall the Blues' first computer system was installed over 10 years ago. It was state of the art then and served well. The system was stretched and stretched to meet increasing demands. At the turn of the recent decade it was decided to start anew.

The arrival of IRBS means up-to-the-minute computer technology. Its planners say it will handle information quickly, accurately and economically. It will bring automation and flexibility to bear on claims processing — to

maximize efficiency. The system will be able to merge and process claims from different lines of business simultaneously.

A major advantage to participating physicians will be the receipt of a single check covering multiple claims. Further, the "par" doctor will receive direct and prompt payment for benefits available under Major Medical if he/she files the claim. And additionally, specific explanatory messages will be provided on claims under question.

On top of these important new claims processing advantages will be access to more complete subscriber data. The enlarged capacity for recording utilization experience will enable the Blues to tell their major group accounts more precisely where the dollars are being spent. Out of all this comes the potential for more accurate rate projection. The process of tailoring coverage to fit the budget and health care needs of an employee group will be made easier.

The system will integrate information on all lines of coverage (dental, pharmacy, etc.) to demonstrate what cost impact may result from deductibles, or co-pay, and also to more accurately coordinate benefits when multiple coverages are held by a subscriber. The new sophisticated technology will accommodate comprehensive benefit packages without difficulty. For example, the heretofore manually administered Comprehensive Major Medical option will become automated and more accessible to subscribers.

New claim forms and explanations of benefits are part of the emerging system. In November, December, and January, nearly 20 workshops are occurring around the state under Blue Cross/Blue Shield auspices. At each, IRBS is being explained. It'll take a bit of time and patience for the new procedures to become ingrained.

But who knows, IRBS may be a key to cost effective quality health care in the 1980's. It deserves a good try.

December 1981

Journal of the Iowa Medical Society



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